

**Adults' experiences of posttraumatic growth during Eye Movement  
Desensitization and Reprocessing therapy, and the role of the therapeutic  
relationship in facilitating growth.**

**By**

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## **Declaration**

This work or any part thereof has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). Save for any express acknowledgments, references and/or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts, with supervisory assistance from Dr Wendy Nicholls and Dr Lee Hulbert-Williams, and with no other person.

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## Abstract

**Introduction:** Recent developments in the study of trauma responses have shown how some people may experience positive and life altering changes following traumatic life events which have been described as posttraumatic growth. Research is beginning to examine the role of trauma treatments in the facilitation of posttraumatic growth.

**Aim:** This study sets out to explore participants' experiences of posttraumatic growth during Eye Movement Desensitization and Reprocessing therapy, and the role of the therapeutic relationship in facilitating posttraumatic growth.

**Method:** Semi-structured interviews were carried out with participants to examine their phenomenological experiences.

**Methodology:** Interpretative Phenomenological Analysis was employed to consider emergent meanings and themes within a hermeneutic circle of interpretation.

**Participants:** Seven participants were interviewed who had received Eye Movement Desensitization and Reprocessing therapy within National Health Service primary care psychological therapy services for posttraumatic stress disorder.

**Findings:** Four superordinate themes emerged from the analysis of the participant accounts including: (i) Safe and secure; (ii) Taking back control; (iii) Reconstructing the self; and (iv) Journeying beyond trauma to the future.

**Conclusions:** Person-centred conditions and client-therapist attachment were important elements of the therapeutic relationship which provided participants with the safety, trust, and relational depth necessary for the facilitation of experiences of posttraumatic growth during Eye Movement Desensitization and Reprocessing therapy.

**Implications:** The findings emphasise the importance of a clinical focus on the quality of the therapeutic relationship as a facilitative therapeutic environment allowing affective-cognitive processing and the emergence of posttraumatic growth.

**CONTENTS****Research Dossier**

Acknowledgements	1
------------------	---

**Chapter 1: Introduction**

1.1. Outline of the Research Dossier	3
--------------------------------------	---

1.2. Introductions to the Research Topic	5
--	---

**Chapter 2: Literature review**

2.1. Trauma, Posttraumatic Responses, and the view from Applied Psychology	7
--	---

2.2. Adaptive Outcomes following Trauma	9
---	---

2.3. Defining Posttraumatic Growth	11
------------------------------------	----

2.4. Theoretical Foundations of Posttraumatic Growth	13
--	----

2.5. Research into Treatment and Posttraumatic Growth Outcomes	18
--	----

2.6. The Therapeutic Relationship in Trauma Treatment and Posttraumatic Growth	25
--	----

2.7. Concluding Comments and The Research Aims	30
--	----

**Chapter 3: Empirical Research Method**

3.1. Methodological Rationale and Epistemological Foundations	33
---	----

3.2. Participants	37
-------------------	----

3.2.1 Sampling & recruitment	37
------------------------------	----

3.2.1.1 Sampling	37
3.2.1.2 Recruitment	37
3.2.2 Inclusion and exclusion criteria	38
3.2.2.1 Inclusion criteria	38
3.2.2.2 Exclusion criteria	39
3.2.3 Participant details	41
3.3. Interview Schedule Development	42
3.4. Interview Context	45
3.5. Procedure	47
3.6. Data Analysis Process	48
3.7. Trustworthiness, Quality, and Reflexivity	50
3.8. Ethical Considerations	55
<b>Chapter 4: Findings</b>	
4.1. Data Analysis	57
4.1.1 Superordinate theme: Safe and secure	58
4.1.1.1 <i>Allaying uncertainty</i>	58
4.1.1.2 <i>Comfortable and at ease</i>	61
4.1.1.3 <i>Professional and knowledgeable</i>	63
4.1.1.4 <i>Developing trust</i>	65
4.1.2 Superordinate theme: Taking back control	68
4.1.2.1 <i>Managing emotions</i>	68
4.1.2.2 <i>Reconnecting with life</i>	69
4.1.2.3 <i>Empowering control</i>	70

4.1.3 Superordinate theme: Reconstructing the self	73
4.1.3.1 <i>Recognising strengths</i>	73
4.1.3.2 <i>Reappraising responsibility</i>	75
4.1.3.3 <i>Newfound self-worth</i>	77
4.1.3.4 <i>Self in relation to others</i>	78
4.1.3.5 <i>Self-acceptance</i>	80
4.1.4 Superordinate theme: Journeying beyond trauma to the future	81
4.1.4.1 <i>Hidden behind locked doors</i>	81
4.1.4.2 <i>Reprioritising the future with family</i>	84
4.1.4.3 <i>Reprioritising future goals</i>	86
4.1.4.4 <i>Letting go of the past to move to a future with compassion and acceptance</i>	88
4.1.4.5 <i>A journey through therapy</i>	92
<b>Chapter 5: Discussion</b>	
5.1. Discussion	97
5.1.1 Summary and assessment of findings	97
5.1.2 Concluding remarks: The facilitation of posttraumatic growth	108
5.2. Implications for practice	112
5.3. Strengths, challenges, and limitations	116
5.4. Recommendations for further research	119
<b>Chapter 6: Reflective appraisal</b>	
Reflective Appraisal of Research	121
<b>References and Appendices</b>	
References	127
Appendix 1: Transcription key	140

Appendix 2: Therapist introductory letter	141
Appendix 3: Researcher's introductory letter	142
Appendix 4: Participant research information sheet	143
Appendix 5: Interview consent form	146
Appendix 6: Semi-structured interview schedule	148
Appendix 7: Demographics Sheet	149
Appendix 8: Psychological Well-Being Post-Traumatic Changes Questionnaire	151
Appendix 9: Interview debriefing sheet	152
Appendix 10: GP Template Letter	154
Appendix 11: Example 2 <sup>nd</sup> stage transcript analysis	155
Appendix 12: Researcher whiteboard workings	156
Appendix 13: Example 3 <sup>rd</sup> stage transcript analysis	157
Appendix 14: Example participant abstracted themes	158
Appendix 15: Example participants' theme / extracts spreadsheet	160
Appendix 16: SAS Research proposal approval	161
Appendix 17: BSEC Ethical Approval	162
Appendix 18: NRES Ethical Approval Original Submission	163
Appendix 19: NRES Ethical Approval Amended Submission	166

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## **Dedication**

I would like to dedicate this doctorate to the memory of my parents.

The encouragement, belief, and wise words which you both gave me throughout your lives enabled me to become the person I am today. Completing this doctorate journey despite your sad passing during this final year Mum is a tribute to the resilience and growth that you both inspired in me.

# **Chapter 1 – Introduction**

## **1.1. Outline of the Research Dossier**

Chapter 1 provides the reader with a brief outline of the research dossier and an introduction and contextualisation of the research topic.

Chapter 2 contains a comprehensive literature review of the research area which sets out to inform the subsequent research aims through acknowledgement and critical review of the current empirical evidence in the area of Posttraumatic Growth (PTG). Firstly, the review will set the research topic in context considering the relationship to psychotraumatology, epidemiology, and symptomology. The review will then move beyond this introduction to evaluate how PTG is conceptualised and the relationships between PTG and current treatments for trauma. The review concludes with consideration of the role of the therapeutic relationship in facilitation of PTG and develops the research aims from the limitations noted within the examination of the current research literature.

Chapter 3 describes the methodology involved in the study, providing the epistemological rationale underlying the research and an explanation of the methodological design, validity, and analysis within the research study.

Chapter 4 is the data analysis of the participant narratives. An account of the initial coding of meaning units into sub-thematic categories is given, followed by the development of emergent superordinate themes evidenced within the interpretation of the participants' textual data.

Chapter 5 is the discussion providing a summary and critical evaluation of the findings in light of the data analysis, and with reference to the theoretical understanding of the topic area and

the emerging findings. Theoretical and practice implications of the research are then discussed and consideration is given to the limitations of the current study and areas for further research.

Chapter 6 is a reflective appraisal of the researcher's experience of carrying out the research, considering how this has added to his development as a researcher, the challenges of the research, and the wider conceptualisation of the scientist-practitioner role within the development of a trainee moving towards qualification as a Counselling Psychologist.

## 1.2. Introductions to the Research Topic

Across the course of an individual's life there exists the potential to experience many difficult life events and personal adversities that can challenge the person's ability to cope psychologically and emotionally. Illness, bereavement, relational and environmental traumas are just a few of the life challenges that can often result in personal distress and several psychological and emotional difficulties ranging from depression and anxiety, through to more well-defined specific psychological difficulties such as posttraumatic stress disorder (PTSD) and complex dissociative states (Briere, 2004). The professions of psychology and psychiatry have focused their efforts on working towards alleviating these negative consequences of trauma with an increasing focus on evidence-based treatments that can return the individual who has been through trauma to a pre-trauma level of functioning where their symptoms of distress are ameliorated (Resick, Monson, Gutner, & Maslej, 2014). It is evident that this reduction in the distress of individuals who have experienced trauma is a very important and necessary focus for psychology in both the applied and research fields. However, with the development of a focus on positive psychology in the nineteen-nineties attention has increasingly turned towards a more salutogenic approach to psychological and emotional difficulties (Gillham & Seligman, 1999). Here the focus of applied and research attention not only acknowledges the importance of the negative consequences of trauma but also emphasises the experiences of people who report positive changes following their trauma experiences (Joseph & Linley, 2008a). These positive changes have variously been described as benefit finding (Affleck & Tennen, 1996), thriving (O'Leary & Ickovics, 1995), stress-related growth (Park, Cohen & Murch, 1996), and adversarial growth (Linley & Joseph, 2004). One of the most widely acknowledged theories of positive change following trauma has emerged through the work of Tedeschi and Calhoun (1996) who have described such change as *posttraumatic growth* (PTG).

In the literature review that follows, an account of the processes, theory, research evidence-base, and clinical treatments associated with trauma and PTG will be considered in order to garner

knowledge, stimulate rigorous debate, and suggest future research directions around the phenomenon of PTG (Hagger, 2012). Consideration will initially be given to the prevalence of trauma experiences and the emotional and psychological impact of distressing life events. The focus of the review will then move to consider how some people adapt to these aversive life events and can gain positively from their struggle with their trauma. This positive adaptation will be explored in relation to an understanding of PTG from a theoretical perspective examining the processes involved in PTG and moving on to consider the occurrence of PTG found within trauma treatments for PTSD. Since its inception, counselling psychology has taken as one of its fundamental tenets to be the importance of the role of the therapeutic relationship in alleviating distress, along with the acknowledgement of the psychosocial growth of the individual being at the centre of any therapeutic intervention (Manafi, 2010). From this perspective, the profession finds itself well positioned to examine and gain understanding of the therapeutic practitioner's role in the facilitation of PTG within existing therapies in addition to the alleviation of emotional and psychological distress following traumatic experiences. It is the aim of the following literature review to move beyond investigation of trauma processes and PTG in isolation by considering and reviewing the current psychological approaches to treating trauma and examining where the intersection lies between trauma-focused treatments, the therapeutic relationship, and current formulations of trauma, PTG and recovery.

## **Chapter 2: Literature review**

### **2.1. Trauma, Posttraumatic Reactions, and the view from Applied Psychology.**

Trauma can be experienced in many forms, from single incident traumas at one particular point in life, through to more complex, cumulative traumatic experiences across the life course (McFarlane & Girolamo, 1996). In the aftermath of an aversive life event people can experience many psychological, emotional, and physiological symptoms (Farrell, 2008). These reactions can ameliorate over time as the person recovers and demonstrates resilience sufficiently to readjust to the trauma experience. However, sometimes these reactions can become more problematic and enduring where the person will find that the traumatic event leaves them with prolonged distressing symptoms. The severity and persistence of a person's symptoms associated with post-trauma reactions can lead to a clinical diagnosis of PTSD dependent on the individual's presentation. Within the American Psychiatric Association's current Diagnostic and Statistical Manual of Mental Disorder (5th ed., DSM-V, American Psychiatric Association, 2013) these symptoms have been clustered and categorised around four criteria. These include, *Criterion B*: intrusions of recurrent, involuntary trauma-related memories and dreams, dissociative reactions, psychological distress and physiological reactions to trauma-related cues. *Criterion C* concerns avoidance of trauma-related thoughts, feelings, or reminders of the traumatic event. *Criterion D* encompasses negative changes in thoughts and mood including; negative self-beliefs or beliefs and expectations about the world; distortions of blame and responsibility in relation to the cause of the traumatic event; an inability to remember key aspects of the traumatic event; negative feelings of fear horror, anger, guilt or shame, and lacking positive emotions or interest in activities previously engaged in. *Criterion E* involves heightened physiological arousal; an exaggerated startle response; feelings of irritability or anger; problems in concentration and with sleep. In order for a clinician to make a diagnosis of PTSD the

client who presents with these symptoms must have experienced them persistently for more than a month demonstrating significant distress and impairment. The symptoms must also be associated with having either been exposed to or witnessed actual or threatened death, sexual violence, or serious injury. This exposure can be either directly experienced, or indirectly through learning of a close friend or relative's experience of these events, or through professional engagement in the traumatic event.

Evidence from epidemiological studies has highlighted the prevalence of experiencing a traumatic event over a lifetime and the subsequent impact of these events. In a study carried out with a national American population by Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) the incidence of trauma experiences was examined finding that 60.7% of men and 51.2% of women experienced at least one traumatic event across their lifetimes with 7.8% of people experiencing clinically significant levels of PTSD. In the British Adult Psychiatric Morbidity Survey, which examined the prevalence of mental health difficulties in the British population, it was found that 33% of adults reported having experienced a defined trauma during their adult life, and 3% of people surveyed met the criteria for PTSD at the time of the survey (National Centre for Social Research, 2009). Clearly these figures highlight the extent to which traumatic life events can lead to substantial distress. However, what these prevalence studies also reveal is the substantial number of people who do not go on to develop clinical difficulties (Norris & Slone, 2014). As Bonanno (2004) highlights, the normal response to trauma is for people to work through this as part of the natural adaptive processing using all the available social and coping resources from their own lives. For the majority of people who experience a traumatic event they will recover using these resources. Herman (1992) further emphasises how this recovery involves the development a renewed sense of safety, stabilisation of trauma symptoms through emotion regulation, the development of personal control and trust, and a re-storying of their lives. These changes can then lead to an accommodation of the trauma experience into an existing schematic framework described by Horowitz (2011) as a

*completion principle*, and by Janoff-Bulman (1992) as a restructuring of the person's assumptive world.

In the development of research and clinical understanding of trauma responses and PTSD there has appropriately been a focus on these negative consequences to trauma in order to help alleviate the psychological and emotional distress people experience. However, over recent years there has been a movement towards a salutogenic perspective within the field of applied psychology spearheaded by Seligman and Csikszentmihalyi (2000) with their call for a *positive psychology* shifting the emphasis of research and clinical application towards consideration of adaptive outcomes. For Seligman and Csikszentmihalyi, this call represented a view of psychology not wholly dominated by an illness ideology of mental health but by a more holistic and wider contextual understanding of the diverse responses to life challenges and traumatic events.

The evidence of people naturally recovering from trauma, and a renewed consideration of positive adaptation within psychological research, precipitated investigation into the processes and experiences of those individuals who were able to adapt and move beyond their trauma experiences. Applied psychology has therefore been building a knowledge base examining the wider sequelae of traumatic events. This wider focus has considered not only negative trauma outcomes but also how there exists the possibility for seemingly paradoxical eudaimonic experiences of growth and positive psychosocial change which moves far beyond recovery and resilience (Tedeschi & Calhoun, 2004; Joseph & Linley, 2006). The review now moves to examine these positive experiences following traumatic events.

## **2.2. Adaptive Outcomes Following Trauma**

There has long been an emphasis within philosophical and religious narratives across the course of history of the positive changes that can occur for individuals as a result of experiencing many difficult and personally challenging events in their lives. As Tedeschi and Calhoun (1995)



highlight, many early philosophical and historical accounts of life experience drew attention to the way life's adversities could lead to individuals gaining deeper insights into their lives and their sense of identity. Within the humanistic field of research and psychotherapy there has been a recognition that positive adjustment could also result from the experience of trauma. Frankl (1963) pointed out the extent to which, even when facing the greatest magnitude of dehumanisation, people can come through these experiences with their will to find purpose, hope, and meaning sustaining them in these circumstances. In a synthesis of a growing body of humanistic research during the nineteen fifties and sixties concerning the development of the self, Maslow (1968) claimed that there existed an underlying propensity for the individual to strive towards self-actualisation through a growth motivation in order to reach a greater sense of being in the world:

We learn also about our own strengths and limits and extend them by overcoming difficulties, by straining ourselves to the utmost, by meeting challenge and hardship, even by failing. There can be great enjoyment in a great struggle and this can displace fear. (Maslow, 1968, p. 221)

Rogers (1959) similarly saw the human condition and the development of the self through his understanding of the self-actualisation process as an inherent drive towards personal growth and being *fully functioning* without recourse to a discrepancy between self and experience (Joseph, 2004). With the move towards these more phenomenological understandings of human experience, the existential psychotherapies have also focused on the way individuals can grow following intense challenges to their self and world-views. Yalom and Lieberman (1991), in studying the phenomenon of growth following bereavement, showed how the existential challenge of traumatic loss can lead to a re-evaluation of meaning in life. In this re-evaluation, Yalom and Lieberman believe there is an unlocking of a human potential and deep capacity for change and growth following trauma.

### 2.3. Defining Posttraumatic Growth

As can be seen from the discussion into these early considerations of the positive outcomes of trauma, it has been recognised that adversity and trauma can, in some instances, result in positive outcomes for an individual. Over recent years the development of the positive psychology movement has been influential in considering a strengths and growth-based approach to the individual and their treatment across many emotional and psychological difficulties (Maddux & Lopez, 2015). This change has been mirrored in the field of psychotraumatology with new insights into the process behind the growth experience beginning to be revealed through the research of many psychologists working within the area of trauma. Tedeschi and Calhoun (1996) have proposed a cogent conceptual model of PTG through examination and synthesis of the pool of research into positive changes following trauma. In examining the concept of PTG, Tedeschi and Calhoun formulated the structure of positive changes after trauma across three broad domains of change:

- Changes in life philosophy
- Changes within the area of self perception
- Changes in relationships with others.

Within these three overarching domains of change they further defined five functional factors through their development of a quantitative assessment measure of PTG known as the Posttraumatic Growth Inventory (PTGI):

- A changed personal understanding of self, where the person acknowledges their strengths and self-efficacy but also recognises their vulnerability.
- Changes to the interpersonal domain of relating to others after trauma, where there is a greater sense of deepening relationships, a need for genuine intimacy and compassion for others.

- Life philosophy changes where there is a greater appreciation for life and what is important to the individual in their life and priorities for their life
- Spiritual change where the individual finds a deeper faith and connection to something greater than themselves either religiously or by finding a higher purpose, or by facing of existential challenges leading to a transcendent meaning for the person's life
- New possibilities for the person's life, where individuals reprioritise the direction for their life and identify more fulfilling ways to engage in life

These experiences of posttraumatic growth have been shown to occur across many different traumatic life events and adversities including personal illness, disability, physical and sexual abuse, environmental disasters and many other areas of research as outlined in a review of life events and growth carried out by Linley and Joseph (2004). Although Tedeschi and Calhoun (1996), and Linley and Joseph, emphasise how PTG can be experienced by individuals across many different types of traumatic life events, they are very clear to assert that this in no way detracts from the evident distress and devastation that people going through trauma experience, and that not all people going through trauma will experience positive changes or PTG.

Tedeschi and Calhoun (1996) further found that there was an overarching self-state associated with these changes which was an openness to experience and a move within these individuals to an active engagement with life following trauma. This engagement and positive experience of change offers an insight into the way people have the possibility of transcending their traumatic experiences, with PTG representing not simply an outcome but are an experiential process of change. Given this growing realisation and awareness around these reports of PTG, attention has begun to focus on the theoretical understandings of the processes lying beneath these reports of growth.

## 2.4 Theoretical Foundations of the Posttraumatic Growth Process

From their growing evidence on the phenomenon of PTG, Tedeschi and Calhoun (2004) proposed a *functional-descriptive* theoretical understanding of the processes involved in experiences of growth. Taking a cognitive processing perspective, their understanding of PTG acknowledged the work of Janoff-Bulman (1992) who suggested that an individual holds a number of schematic assumptions about themselves, about the world they inhabit, and their relationship to that world. From this perspective, traumatic events can challenge these beliefs and shatter these assumptive worlds leaving the individual with a discrepancy between how they viewed themselves and the world before the traumatic crisis, and the information they have following the trauma. For Tedeschi and Calhoun, it is the struggle with the trauma which is the crucial factor in the person's experience of growth. The trauma event acts as a seismic challenge to the person's beliefs and assumptions including their perceived safety, the predictability of events, and how influential they can be to control their world. Through a period of reflective rumination, a narrative reconstruction of the life story, and social disclosure, Tedeschi and Calhoun suggest that cognitive and emotional processing of this discrepant information takes place and the individual begins to reconstruct their personal schema and assumptive worlds over time.

Support for Tedeschi and Calhoun's emphasis on the role of the cognitive processing of trauma information related to PTG has been shown through research considering ruminative and cognitive processing. Taku, Cann, Tedeschi, and Calhoun (2009) investigated the role of rumination after trauma and found that intrusive involuntary rumination soon after a traumatic event was significantly associated with PTG. Deliberate reflective rumination was more strongly associated with PTG at a longer duration after the aversive event. This suggested that intrusive rumination may be involved in the experience of PTG initially in priming cognitive processing, with more constructive reflective rumination having a longer-term association with growth.

Tedeschi and Calhoun's theory represents a major contribution to the understanding of the process by which PTG occurs by incorporating the findings of the research into cognitive processing. However, it has been argued that the theory does not fully account for the occurrence of continued negative emotional adjustment that has been shown to exist alongside experiences of PTG (Maercker & Zoellner, 2004). As Zoellner and Maercker (2006, p. 649) have further suggested, Tedeschi and Calhoun's model, although valuable as a heuristic pointer to future research, is "not reliably linked to measures of adjustment." This is a point supported by a meta-analysis of benefit finding carried out by Helgeson, Reynolds, and Tomich (2006) questioning the role of PTG in relation to wider well-being. Maercker and Zoellner (2004) further suggested that in some instances these accounts of growth could be counterproductive to positive psychological well-being. Drawing on findings of illusory coping mechanisms researched by Taylor (1983), Maercker and Zoellner proposed the *Janus-faced model* of PTG. Within their formulation, they suggest that PTG can represent either an adaptive constructive process in line with Tedeschi and Calhoun's formulation, or it could represent a self-deceptive, illusory coping strategy to 'counterbalance emotional distress' protecting the individual from the emotional vicissitudes of the aftermath of trauma. Given these apparent concerns, it can therefore be suggested that this functional-descriptive theory could be seen as too limited in its understanding of the causal mechanisms and processes involved in the individual's struggle towards growth.

In order to consider these limitations, and further integrate existing perspectives on trauma outcomes, Joseph and Linley (2005) proposed a reformulation to the theoretical understanding of growth with the *organismic valuing theory* of positive change. Drawing on the person-centred approach to psychopathology, and Rogers' notion of the *organismic valuing system* (Rogers, 1959), Joseph and Linley proposed that people have an inherent tendency towards development and growth of their authentic self-concept. Their theory also takes account of the cognitive and affective processing theories known to be involved in the development and recovery from PTSD such as the principle of *completion* (Horowitz, 2011) and relates this to the experience of growth. They suggest

that there is an intrinsic motivation to move towards completion, or the working through of the discrepant trauma information by a process of *assimilation* or *accommodation*. If the person assimilates the new trauma related information into their existing schematic and assumptive structures then they can recover from their trauma symptoms but remain vulnerable to future traumas. However, if they process the information through reflective cognitive and emotional processing then they can forge an updated schema template. The trauma-related information can then be accommodated within the assumptive schema memories leading to new self and world understanding commensurate with the experience of PTG.

Central to Joseph and Linley's proposals are the role of self-concept change, meaning making, and the socio-cultural context in which meaning making takes place. They propose that the significant driver in this change is the meaning-making process which provides the framework for the individual who has experienced a traumatic event to integrate their experience of their struggle with trauma into a more authentic sense of self and assumptive world.

Evidence from research within the fields of meaning making, and narrative self-identity theory provide some support to this proposal. In testing a meaning-making model of positive transformation after trauma, Park, Riley, and Snyder (2012) examined the survey responses of one thousand and four representative adults six weeks after the American 9/11 terrorist attacks. Their findings revealed a significant link between meaning making and subsequent experiences of posttraumatic growth. Pals and McAdams (2004) suggest that meaning making goes further than just sense-making but is intimately connected with the narrative restructuring of the self and a positive transformation of the self-identity. This view of a restructuring of the self emerged from research carried out by Pals (2006) who examined the narrative of participants who had experienced life adversities and found that a reconstruction of their self-identities occurred through a changed narrative engagement with the challenge of the traumatic experiences. As Neimeyer (2006) further proposed, evidence of the role of meaning in reactions to trauma and adversity can lead to a reworked self-understanding which is forged through integration of the person's *micro-*

*narratives* of experience with superordinate *macro-narratives*, which are analogous to schematic change and a changed construction of the self-beliefs evident in their reports of PTG. Joseph and Linley's self-congruence theory can also be suggested to align with case-study research which has examined a dialogical self-theory of change, where a variety of contrasting *self-positions* or *self-states* exist for the individual who has experienced traumatic events. As they then work through the process of recovery there is then a reorganization of their self-system (Hermans & Hermans-Jansen, 2004).

Joseph and Linley's account goes a long way to explaining the process of growth in-line with humanistic and narrative principles of self-identity and change whilst also incorporating what is known from cognitive and affective theories of trauma responses. The model also provides some understanding around the question posed by Zoellner and Maercker (2006) regarding adjustment more widely, where it is proposed that PTG represents a phenomenon that is related to *psychological well-being* as distinct from *subjective well-being* which is not related to growth experiences but wider adjustment.

Joseph, Murphy, and Regel (2012) have more recently elaborated on the organismic valuing system incorporating the theory into their wider affective-cognitive theory of PTG. They suggest that the model offers an integrative and multidimensional understanding of PTG which also takes account of the research perspectives into PTSD alongside the empirical evidence on the development of PTG. The model also emphasises points within the recovery process which have a particular relevance for both trauma treatment but also the facilitation of PTG. These points include the importance of exposure, information processing and cognitive reappraisal of the trauma, emotion regulation, and psychoeducation.

The conceptualisation of PTG within the affective-cognitive processing model put forward by Joseph, Murphy, and Regel (2012) relates PTG to the psychological well-being a person experiences rather than their subjective well-being, as discussed above. This emphasis on psychological well-being has also led to the development of a self-report measure of PTG which

takes account of the definition of PTG as relating to psychological well-being. This is the Psychological Well-Being Post-Traumatic Changes Questionnaire developed by Regal & Joseph (2010). As well as differentiating between psychological and subjective well-being, the PWB-PTCQ also takes into account the coexistence of positive and negative changes following trauma which previous measures of PTG have not encompassed. Joseph et al. (2012) consider this as adding greater validity to the measure in relation to current conceptualisations of PTG.

The affective-cognitive model proposed by Joseph, Murphy, and Regal (2012) has therefore provided greater clarity regarding the processes involved in experiences of PTG. The model also builds upon the psychosocial model of trauma recovery proposed by Joseph, Williams, and Yule (1997) where the social environment is seen as crucial to the processing of trauma-related information and the valenced direction of recovery.

In support of this wider psychosocial conceptualisation of response to trauma, a recent study by McDonough, Sabiston, and Wrosch (2014) found that social support was significantly related to subsequent reports of PTG but also identified that it was support specific to the person's trauma experience which was related to this positive change. They suggest that it is important to understand that it is not only the provision of social support in general which can lead to PTG but the type and relevance of the support that is of prime importance to the individual. McDonough et al. also point out that these findings could also be relevant to the clinical context where it may be important to provide a facilitative environment for individuals to explore their experiences and encourage their moves to seek appropriate social support around their experiences.

With an integrative theoretical base founded on clinical research, Joseph, Murphy and Regal (2012) provide a comprehensive theory which allows the examination of different points within the process of change where theory and current therapeutic practice intersect. Examination of these points could provide greater clinical understanding of the role not only of recovery but for the additional move towards PTG following psychological trauma treatment. In order to gain a wider



understanding of the clinical significance of PTG for the practice of counselling psychology the review now turns to the role of psychological treatments for trauma.

## **2.5 Research into Treatment and Posttraumatic Growth Outcomes**

Research into the factors associated with posttraumatic growth have helped to increase understanding around the processes involved in positive change following trauma and offer up some pointers towards the facilitation of PTG within treatments for trauma. The prominence of cognitive and affective processing, narrative meaning making, and the interpersonal psychosocial factors shown important to the development of PTG leads to consideration of the role current therapies for trauma may have in offering a potential environment for the facilitation of PTG in the clinical context.

As scientist-practitioners, Counselling Psychologists endeavour to integrate theoretical and experiential factors in order to consider the applied aspects of phenomenon (Goldstein, 2009). Within the field of research into PTSD and PTG this integration of theory, process, and practice has also been considered important to understanding the phenomenological experiences of trauma and subsequent outcomes. For this reason, the review now turns to consideration of treatments for trauma and in particular to the experience of PTG. By turning attention to this applied area of trauma, the review sets out the background clinical platform from which to consider the importance of the role of the therapist within the conversation around recovery from trauma and PTG. Research studies looking into the effects that post-trauma treatments may have on positive adaptations and PTG have mainly focused on current first-line treatments such as trauma-focused cognitive-behavioural therapy (TF-CBT) and exposure therapy which are two of the recommended treatments for PTSD within the National Institute for Clinical Excellence guidelines (2005).

Research carried out by Antoni et al. (2006) considered an existing cognitive-behavioural stress management group programme which had been used to assist patients with their coping following their diagnosis of breast cancer and subsequent surgery. Given the growing interest in

salutogenic outcomes following trauma the researchers examined whether there was any positive change for the patients following their treatment in relation to improvements in mood, but also through measures of positive adaptation including benefit-finding, optimism, and emotional processing. Using latent growth-curve modelling they found that for the intervention group there were reported increases in benefit-finding, positive states of mind, positive affect and emotional well-being, and positive lifestyle changes. With regards to the specific treatment components, the study found that the relaxation skill component within the treatment was the main mediator between treatment and the positive outcome effects of the study. It can be seen from the study that specific components of this cognitive-behavioural based group treatment appeared to relate to improved adaptive outcomes for participants, particularly the confidence of the participants in their ability to use relaxation techniques to manage their distress. Specific treatment components therefore seem intricately linked to positive adaptation. However, Antoni et al. also found that increases in emotional processing were a further mediating factor for the treatment's relationship to benefit finding between groups suggesting that other factors may be at work in the development of growth experiences. As has been noted earlier in this discussion, social-relational elements have been suggested as key to the development of PTG. The participants who received the specific treatment components in the Antoni et al. study also experienced a therapeutic group facilitator, and wider relational engagement in the group. It could be argued that this relational element may have contributed to the improved benefit finding for the treatment group, above and beyond the specific relaxation component and may account for the unexplained variance in the model used in the study. As Antoni, Carver, and Lechner (2009, p. 210) acknowledge, a "receptive social network" could be a further factor in the effects on benefit finding for this population.

From these early studies considering therapeutic interventions, benefit finding and PTG it can be seen that there is a possible relationship between people engaging in particular treatment interventions and improvements to their personal growth following trauma. These findings provide a tentative indication of the facilitative role therapy may have in experiences of PTG during

therapy. However, ambiguity remains in their inability to fully clarify the relationship between the traumatic experiences of the individuals, the trauma treatment provided, and positive psychosocial growth. Given the heterogeneity of the measures of distress and positive change used within the studies discussed so far, it could be argued that research which has more well defined measures of trauma symptomology and positive adaptation, such as PTSD and PTG respectively, could provide clearer understanding about the relationship between treatment and PTG outcomes.

To understand the relationship between experiences of PTG and psychological treatments, more recent studies have focused on treatments for specific occurrences of PTSD and the relationship to PTG. In a study carried out by Hageraars and van Minnen (2010) the relationship between exposure treatment for PTSD and outcomes of PTG was examined. Participants who had experienced varying traumatic events were measured for their experience of PTG using the PTGI pre- and post-therapy. Hageraars and van Minnen found that there was a significant improvement in the participants' measures of growth following the exposure therapy. In follow-up analysis of the sub-factors on the PTGI measure they found that *Personal Strength*, *New Possibilities* and *Relating to Others* were the main sub-factors where increases occurred. From these findings, they suggested that these specific component elements of the growth measure may be related to the elements of mastery and improvements in social interactions developed through the exposure treatment. They further speculate that it may be beneficial to consider wider forms of therapy, such as cognitive therapy, in order to elucidate whether specific components of differing treatments affect the growth sub-domains differentially.

Hageraars and Van Minnen's study cautiously draws attention to the specific potential effects manualised treatments may have on experiences of personal growth. In order to consider the relationship between a cognitive-behavioural intervention for PTSD and PTG, Knaevelsrud, Liedl, and Maercker (2010) examined the effects of an internet-based CBT intervention with a German-speaking population. Pre- and post-therapy measures of PTG, openness, and optimism were taken and analysis of the data found significant improvements to PTG were experienced following

treatment. From these findings, the researchers suggested that the facilitation of PTG may be the result of the cognitive processing aspect of the treatment intervention which could have had an influence on changing the participants' cognitive schemata. They also found a positive correlation between PTSD symptom reduction, particularly intrusions, and improved PTGI scores. They suggested that PTG may represent an indicator of positive adaptation, with the reduction of intrusions allowing the process of PTG to occur. In conclusion, the researchers felt that the cognitive-behavioural intervention may offer the potential to promote PTG and they suggest further research in this area of cognitive processing following trauma to ascertain this.

The study by Knaevelsrud et al. (2010) provides some further support to the suggestion that a therapeutic intervention could be helpful in facilitating people's move towards PTG. However, caution should be taken in this as the study has several limitations that could have meant the findings and the researchers' interpretations of the data may not support this view. From a methodological perspective, recruitment to the study purely by way of the internet may have biased the studies findings. Using the internet introduces a self-selection bias as it preferences those individuals who have access to the internet, and who are cognisant and easily capable of utilising the internet and information technology (Hewson & Laurent, 2008). This would eliminate many participants from the general population who had experienced trauma but who would not wish to engage in research through this method. Further challenges to the generalisability of the study include the gendered ratio of the study participants where ninety percent taking part were female, suggesting again that the results may not be generalisable over a more representative general population.

Despite these limitations, the study by Knaevelsrud et al. (2010) highlights how changes in PTG appear to occur during treatment and they propose that it is the cognitive processing element of the CBT intervention that is the active process in these changes. However, it should be pointed out that the participants in their study had regular contact with the therapist via the internet and the quality of this relationship was not considered and, as an earlier study into the therapeutic alliance

and the internet highlighted, this may have been influential (Knaevelsrud & Maercker, 2007). It can therefore be argued that the active elements in the intervention may not solely have been the result of the *technique-driven* processing but may have reflected wider common factor variables such as the therapeutic relationship which may also have been influential to the changes noted.

A randomised control trial carried out by Zoellner, Rabe, Karl, and Maercker (2011) also considered the development of PTG following a cognitive-behavioural intervention specifically for PTSD following severe motor vehicle accidents. They measured the impact of the intervention on changes in PTSD, optimism, openness to ideas and feelings, and PTG following treatment. The research analysis found no significant main effect for PTG improvement pre- and post-intervention or any interaction effects, with the exception of two components of the PTG measure, *new possibilities* and *personal strength*, which did have significant effects. Zoellner et al. suggested that their results did not therefore support a link between the overarching construct of PTG and treatment. They speculated that the significant findings around the sub-domains of PTG may have resulted from the immediate mastery changes inherent in participants overcoming their symptoms of PTSD. The improvements in avoidance symptomology and maladaptive cognitions were suggested as accounting for increased re-engagement in life rather than a broader changed philosophy of life. In considering these results further, it can be suggested that as the study had only twenty participants in each of the treatment and control groups then this may have limited the power effects within the statistical model to render meaningful significant results with a resultant small effect size. Additionally, the participant population was not representative across gender, trauma type, and culture, in order to generalise these findings to a wider conversation about the role of treatment in relation to experiences of PTG. As with earlier studies, the authors also highlight how quantitative study alone does not provide an adequate understanding of the phenomenon of PTG for individuals who are coping with the aftermath of a traumatic event and call for further empirical investigations including a qualitative exploration.

All of the studies considered so far have examined PTG in relation to cognitive-behavioural treatments and have taken a quantitative methodological approach to the study of PTG. However, few studies have considered PTG with regards to Eye Movement Desensitization and Reprocessing therapy (EMDR). The National Institute for Clinical Excellence (2005) and the World Health Organisation (2013) both recommend EMDR as a first line trauma treatment for PTSD. Given that both TF-CBT and EMDR are important approaches to treatment for PTSD this raises the question whether studies have considered EMDR in relation to PTG.

The use of EMDR therapy for trauma has grown from the theoretical and research evidence gathered since the original inception and development of the technique by Shapiro (2001). The clinical and research work carried out by Shapiro led to the development of a theoretical model of trauma where the symptoms involved in PTSD are seen as resulting from an information processing difficulty. Trauma-related memories and perceptions are suggested in the model to become frozen in “*state-specific form*” within neural memory networks leading to maladaptive responses synonymous with the symptoms of PTSD (Solomon & Shapiro, 2008). Shapiro asserts that EMDR therapy assists in reprocessing these frozen trauma memories and experiences through adaptive information processing (AIP). This AIP is suggested to operate through a sequence of stages of stabilisation and reprocessing where adaptive information is accessed concurrently to the processing of trauma-related experiences through bilateral stimulation of the person’s sensory field. This processing leads to adaptive integration of neural networks which can result in cognitive reappraisals and restructuring around self-perceptions, with improved affect and somatic experience, and a reduction in the symptomology associated with frozen trauma memories. A growing evidence-base into the efficacy of the approach supports the role of EMDR in providing effective recovery from PTSD (Bisson et al., 2007), and suggests its wider application in more complex trauma where the trauma results from past relational adversity in childhood (Korn, 2009). Given the clinical importance of adaptive changes within the information processing model of EMDR, and the increasing use of EMDR within psychological therapy services for trauma

treatment, it can be suggested that consideration into the role of EMDR and experiences of PTG may be beneficial to further understanding into the facilitation of PTG.

A doctoral study carried out by Blore (2012) has considered the role of positive adaptation and PTG from the perspective of EMDR. Blore employed a qualitative design to investigate the narrative post-trauma accounts of twelve participants who had experienced a major road traffic accident and had been through EMDR treatment. Several key superordinate themes emerged from the study including a *network growth* theme which occurred as a result of a *navigational struggle* which the participants experienced following their particular trauma. The research provided a richness of understanding of how participants can experience positive change following trauma and EMDR therapy and allowed Blore to speculate on the role of EMDR in facilitating such changes. Blore's suggestion from the research is that the development of network growth could map onto the eight-stage model of EMDR reprocessing to encompass the positive resourcing procedures with the client, the development of safe place, and the installation of positive cognitions. This research represents an indicator of how a treatment protocol within an existing trauma treatment such as EMDR could offer the potential to assist the client beyond symptom recovery alone and to greater developmental change and PTG.

The preceding discussion of the study carried out by Blore highlights the idiographic nature of the experience of PTG and how this potentially relates to the procedural components of a particular intervention for trauma, in this case EMDR. Research from other therapeutic modalities has also identified how growth can result following traumatic life events but within the context of a specific intervention designed to improve positive adaptation.

A study carried out by Garlan, Butler, Rosenbaum, Siegel, and Spiegel (2010) considered an existential therapy intervention involving the application of a *life tape interview*. This intervention was designed to improve social and familial support and understanding along with wider existential well-being through a reflective life history process. The intervention involved participants diagnosed with cancer talking with their families about their reflections on lessons they have

learned in life and the impact on others. This intervention considered the importance of the social context for disclosure and reflection on subsequent existential anxiety reduction, but also experiences of positive adaptation and PTG measured pre and post-intervention. Following analysis of their data, it was found that the participants experienced improvements in their social familial relationships and those who experienced the most existential threat at the outset of the study showed the greatest improvement in experiences of PTG. Although this study had limitations regarding the lack of a comparator control group, so leaving the findings open to the effects of extreme values within a small sample size, it did highlight how aspects of therapeutic intervention such as reflective disclosure and social support are important to experiences of PTG and to reductions in existential dilemmas.

The review of the research into PTG and trauma treatments has shown that links exist between treatment interventions and experiences of PTG although causal inferences have not been substantiated through these studies. The majority of existing studies speculate on individual cognitive components of the therapeutic techniques employed as influential to growth, whilst others speculatively suggest that PTG maps onto the procedural elements of treatments such as EMDR. However, as can be seen from this review so far, the specific pathways to PTG within therapeutic interventions remain elusive and wider potential causal factors, such as the quality of the therapeutic relationship, may also play an important role in the facilitation of PTG. It is to this wider consideration of therapeutic process-outcome research that the review now turns.

## **2.6 The Therapeutic Relationship in Trauma Treatment and PTG**

Within the field of research into the therapeutic process it has long been acknowledged that the therapeutic relationship plays a key role in the outcomes of therapy (Cooper, 2008). Research into the effectiveness of psychotherapy has consistently found that the therapeutic relationship accounts for a large proportion of the effect of therapy. The American Psychological Association Interdivisional Task Force recently investigated the role of the therapeutic relationship in



psychotherapy outcomes across twenty-four meta-analyses finding that the therapeutic relationship accounted for 12% of therapeutic outcome variance with specific treatment approaches accounting for 8% (Norcross & Lambert, 2011).

Recognising this importance of the therapeutic relationship, many clinical protocols for trauma encourage clinicians to ensure the development of the therapeutic relationship, emphasising the fundamental role this plays in the work of therapy. Foa, Hembree, and Rothbaum (2007) suggest in their protocol for exposure-based trauma treatment that the development of the therapeutic alliance is crucial to the effective implementation of treatment. Within the EMDR approach to trauma treatment developed by Shapiro (2001), the therapeutic relationship has similarly been given prominence with regards to the effective building of rapport. This rapport between client and therapist being important to ensuring the development of trust and safety to allow the client to begin to explore and process their cognitive and emotional experiences associated with their trauma memories. Dworkin (2005) considered how the implementation of the eight phases of the EMDR protocol involves a number of key relational qualities including the use of *empathic attunement* and an *intersubjective awareness*. Dworkin sees the integration of a relational stance within EMDR as indicative of a two-person therapy providing a richer therapeutic environment where the awareness of relational elements can allow reprocessing of blocked trauma-related material through acknowledgment of the potential transference and countertransference reactions between client and therapist. Parnell (2013) further extends this relational perspective within EMDR treatment by postulating that the relational elements of treatment are crucial for more complex trauma where individuals who have experienced attachment-related trauma within their formative years continue to express this attachment pattern in their symptomology as adults. Given that research has found that secure attachment can potentially *buffer* the short and long-term adjustment of trauma survivors (Solomon, Ginzburg, Mikulincer, Neria, & Ohry, 1998) then the role of attachment would seem an important avenue for further research into trauma outcomes and positive psychosocial changes following therapeutic intervention.

In reviewing the extensive research into attachment and psychotherapy, Mikulincer and Shaver (2007) proposed a theoretical model of attachment where the primary attachment figure is perceived as stronger and wiser, where proximity with the attachment figure is sought, where the attachment relationship acts a safe haven at times of threat, and where there is a felt sense of security with their attachment figure in order to explore new and novel experiences. In summarising research into the therapeutic relationship and attachment, Mallinckrodt (2010) builds on this attachment model through consideration of the research into attachment and the therapeutic relationship (Mallinckrodt, Gantt, & Coble, 1995). Mallinckrodt suggests that a similar attachment environment to that described by Mikulincer and Shaver exists within the therapeutic relationship, with the therapist offering similarities to the role provided by a primary attachment figure.

Empirical evidence has shown that attachment security with a supportive other can ameliorate the effects of trauma and mitigate the effects of dispositional attachment style in reacting to a traumatic event. In a study carried out in Israel during the Gulf War, Mikulincer, Shaver, and Horesh (2006) found that individuals who were assessed with dispositional anxious attachment, but who experienced attachment security in their relationships with others on a daily basis subsequent to the trauma, demonstrated significantly less posttraumatic stress symptoms despite any global, dispositional, anxious attachment. This finding is important to this discussion regarding the role of the therapeutic relationship and positive adaptations following trauma as the attachment to the therapist may provide a secure relational context from which to develop PTG, as Mikulincer and Shaver (2007, p. 391) note, “Beyond preventing PTSD, attachment security may also contribute to the reconstruction of comforting, health-sustaining beliefs shattered by trauma – an example of...’posttraumatic growth’.”

Given the important role of attachment to the therapeutic relationship and to particular responses to trauma, it would therefore be beneficial to consider the role of attachment in the development of PTG following traumatic life events, Research has recently turned to this question and considered the associations between attachment and PTG. Salo, Qouta, and Punamaki (2005)

found that secure attachment amongst Palestinian political prisoners was positively related to experiences of PTG. In contrast, Dekel (2007) reported contradictory findings from a research study examining the attachments of wives whose partners were experiencing PTSD, finding that avoidant and anxious attachment styles were related to experiences of PTG. A more recent study carried out by Arikan and Karanci (2012) appears to support the findings of the study by Dekel in that anxiously attached individuals were more likely to experience PTG than securely attached participants.

In considering the role of the therapeutic relationship in trauma reactions, it can be seen that empathic attunement, intersubjectivity, and client-therapist attachment would seem important to any examination into the facilitation of PTG and provide a wider understanding of the experience of PTG from the client's own perspective as they engage in therapy. Several clinical proposals have been made regarding the facilitation of PTG and the role of the therapist within the therapeutic relationship.

Calhoun and Tedeschi (2013) have proposed a modal for the facilitation of PTG which is based on extensive research into the factors associated with the development of PTG. They suggest an *expert companion* role providing attentive listening and empathic attunement in order to gain an understanding of the client's assumptive world and their pre and post-trauma core beliefs and existential fears evident in the narratives around their trauma. Subsequent reflective engagement with the client then involves acknowledgement of the client's negative trauma experiences but also recognises and labels the strengths, capabilities, and changed possibilities across the five domains of PTG which the clients may express in their narrative accounts of their trauma experience.

From this perspective, the therapist provides the relational context of safety within which the clients can explore their unique experiences with openness and security. However, Calhoun and Tedeschi emphasise that this is a therapeutic process which is led by the clients' own phenomenological experience and the therapist should be aware of not imposing expectations of change onto the client but allow them to take this lead. Calhoun and Tedeschi do not see this

approach as a separate therapeutic technique but as an adjunct to existing therapeutic trauma treatments which may extend the effectiveness of current therapeutic approaches beyond symptom reduction strategies as they emphasise: “We will *not* be describing a new form of therapy, but how to maximize the effect of evidence-based trauma treatments” (2013, p. 29).

Calhoun and Tedeschi’s (2013) approach to the facilitation of growth is suggestive of the therapeutic relationship as central to providing the context in which PTG can emerge for the client. Joseph (2015) acknowledges this approach as broadly client-led but believes that it still casts the therapist in the expert role rather than taking a non-directive approach and giving prominence to the client’s own expertise in finding growth and being self-determining. Joseph (2004) suggested that a person-centred approach, where the core conditions of empathy, unconditional positive regard, and genuineness expressed within the therapeutic relationship, allows the development of safety and trust necessary for the affective-cognitive processing of their trauma experiences leading to recovery and the potential for PTG. Flanagan, Patterson, Hume, and Joseph (2015) have recently considered the role of unconditional positive self-regard in experiences of PTG finding that there is a significant relationship between these phenomena but the direction and process underlying the relationship is far from conclusive. As Joseph (2011, p. 160) highlights, the therapeutic relationship which offers the necessary conditions allows the client to experience, “autonomy, competence and relatedness” and the emergence of their innate drive towards personal growth. It could be argued that modelling this unconditional positive regard within the therapeutic relationship therefore leads to the client’s own development of unconditional positive self-regard. This is a suggestion that remains to be examined within PTG research.

## **2.7 Concluding Comments and The Research Aims.**

It can be seen from the discussion regarding the experience of PTG that the facilitation of PTG speculatively involves a therapeutic relationship where core conditions of empathic attunement, mutuality, and therapeutic exploration operate. The presence of these conditions within a therapeutic environment may mirror the contextual safety, trust, and proximity that an attachment framework offers for change and growth to occur. As Meichenbaum (2013) suggests in a discussion of the core therapeutic factors important to client change, the therapeutic relationship operates not only to provide the setting for the application of technique but adds to the processing of trauma in its own right through the intersubjective process between client and therapist.

Calhoun and Tedeschi (2013) suggest that the awareness of the facilitative role of the therapist with regards to PTG could appreciably add to the effectiveness of current therapies not only to assist clients in addressing their distress but moving them into greater psychological well-being beyond symptom recovery. However, it is clear that there is a paucity of research within mainstream therapies and the research that has been undertaken has given emphasis to the instrumental and technical components of therapy such as cognitive and affective processing. These studies have not endeavoured to consider the wider common factors such as the therapeutic relationship in explanations of the movement towards growth that some clients experience. There has also been a narrow focus on TF-CBT whereas other evidence-based treatments such as EMDR have received less attention within the research literature so limiting a full understanding of the processes involved in the facilitation of PTG. Sheikh (2008) acknowledges how research into the facilitation of PTG is in its infancy but states how current trauma treatments have the potential to provide an environment for the facilitation of PTG.

The studies examined in this literature review highlight the current extent of the research endeavour to investigate the role trauma-focused therapies play in facilitating PTG. The review of existing research highlighted several important limitations in the research base which represent

barriers to a full understanding of the experience of PTG and its facilitation. A key limitation in existing research is the extent to which there has so far been an overemphasis on quantitative methodological approaches examining whether therapies can foster experiences of PTG. This reification of a phenomenon such as the experience of PTG into quantifiable measures does not provide a comprehensive understanding of the lived *meaning-making* processes shown to be important to experiences of growth following adversity. In addition, the quality of these quantitative designs has been limited by small sample sizes, often lacking consistency in the definition of outcome measure, and with a narrow focus on trauma-focused CBT. These methodological and design difficulties further reduce the reliability of the results to demonstrate an understanding of the change processes involved in the facilitation of PTG. The almost exclusive focus of existing research on trauma-focused CBT, as opposed to wider therapeutic modalities such as EMDR or humanistic therapies, also stands juxtaposed to current theoretical developments regarding PTG and clinical understanding around recovery more broadly.

The prominence given in the existing research to designs focusing on exploring significant differences between pre- and post-therapy outcomes, although beneficial in acknowledging growth can occur during therapy, do not take account of the rich phenomenological experience of participants going through the therapeutic process.

It is evident from examination of the literature that the reliance on quantitative research has not yet provided a comprehensive understanding regarding the experience of PTG and its facilitation.

The present research represents an attempt to meet these shortfalls in previous research by employing qualitative research that allows exploration of the lived experiences of participants who have been through EMDR therapy. It is felt that Interpretative Phenomenological Analysis would provide a methodological approach where understanding of the experience of PTG, and the role of the therapeutic relationship to facilitate growth, would emerge not through statistical examination of averages across groups of individuals but from the meanings and significance individual participants give to their experiences during EMDR therapy.

Given the limited body of research evidence related to EMDR therapy and PTG, the present research will be carried out with a sample of adult participants who have completed their EMDR treatment for PTSD within the past year and who demonstrate both clinical recovery and PTG at the completion of their therapy. It is proposed that the qualitative study will seek the narrative phenomenological accounts of the participants with the aim of exploring their experiences of PTG during EMDR. The research will then also aim to consider the role of the therapeutic relationship in facilitating any experiences of PTG. In exploring these two aims for the research through the participants' experiences during EMDR therapy, it is hoped that the findings may inform wider clinical knowledge for practitioners working within the area of trauma recovery.

## **Chapter 3: Method**

### **3.1. Methodological Rationale and Epistemological Foundations**

The first step was to consider the potential methodologies which would aid the exploration of PTG following traumatic events and trauma treatments. Previous research had employed both quantitative and qualitative approaches. Qualitative research has provided valuable insights into the lived experience of PTG for individuals experiencing a wide range of traumatic life events and quantitative research has provided understanding of the definition of PTG and the ability to examine it longitudinally over time (Park & Lechner, 2006). The choice of methodology was informed by the specific research aims (Willig, 2013). It was decided that a qualitative phenomenological approach would be taken and Interpretative Phenomenological Analysis (IPA) would be employed to investigating participants' experiences of their therapeutic relationship and PTG as they engaged in their EMDR therapy. This decision was taken with reference to the underlying epistemological positioning of IPA and the alignment of this approach with the current focus of the research.

IPA is predicated on a number of philosophical tenets which have shaped and informed its conceptualisation and methodology. IPA examines the lived experiences of individuals and explores the meanings, understanding, and significance of these experiences within their lives (Smith, Flowers & Larkin, 2009). In proposing this phenomenological exploration of experience, Smith et al. acknowledge the philosophical proposal put forward by Husserl (1931). Husserl described how reflective engagement with the lived experiences in the world can lead to an emergent conscious awareness of the thing for itself, or what Husserl termed the *essence* of a phenomenon. Through a process of *eidetic reductions* or systematic reasoning about the conscious experience of a



phenomenon, the person can move beyond or bracket out their prior assumptions and presuppositions held about an experience to reach the essence of the experience.

For Smith et al., (2009) this philosophical perspective provided the foundation for a focus on reflective engagement with lived experience but remains positioned within a philosophical discourse of descriptive and reasoned understanding of phenomena, rather than a psychologically defined methodological inquiry into the psychological processes at the inter and intrapersonal level. In defining this epistemological position in relation to the psychological study of phenomena, IPA draws on an interpretative understanding of lived experience in the world, or a *hermeneutic* study of interpretation, which owes its foundations to the philosophical investigations of Heidegger (1927). Heidegger further considered the emergence of a person's conscious experience through his ontological conceptualisation of human existence as *Dasein* which translates as *there-being*, where existence is brought to awareness but crucially only through meaningful and intersubjective relations within the lived world of the individual. Thus, Heidegger's proposal was that it was through a reflective engagement and *interpretation* of the thing for itself as it appears which leads to an understanding of phenomenon as it is experienced.

With acceptance of this interpretative stance, IPA aligns with Heidegger's notion of phenomenon emerging into meaningful awareness through interpretation. However, Heidegger also highlighted how the inquiry into events and the understanding that emerges from this is always located from within an assumptive world, as researchers and inquirers are themselves embedded in the world and their ways of interpreting are shaped by their own knowledge and experience. For Heidegger, this represents a key point as it is reflection not only on an account of experience that forms the emergence of understanding but this is formed through the lens of our own prior experience, or what Heidegger terms our *fore-structures*. Within the research environment, interpretation of discourse and text can therefore be biased by our own assumptions and perspectives on the world or events. Heidegger believed that the way through this was to be aware

of these biases and to examine them in order to understand their influence on our interpretations. As Gadamer (1975, pp. 271-272) further elaborated in relation to textual analysis, “The important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meanings.” In this regard, the important focus on *reflexivity* in IPA acknowledges the way fore-structures bias interpretations, and where reflexive self-awareness allows inquiry to move iteratively between our interpretations, our assumptions, and to the revision of our understanding of experience.

For Smith et al. (2009) the researcher is therefore embedded within a relationship with the participant’s account, where the participant is trying to make sense of their lived experiences, and the researcher is trying to understand the participant’s own interpretation of this lived experience. This *double hermeneutic* further defines the position of IPA as a reflexive and idiographic approach located in the particular instances of a participant’s experience. The textual analysis must include an attempt on the part of the researcher to be aware of her or his own role in examining and explicating the production of meaning. Dilthey (1976, p. 237) emphasised how “meaning, comprehension, significance...are only points to the relationship between events and an inner pattern, contained in understanding and required by it.” This idiographic focus on the examination of the *particular* and its relationship to the *whole* within the hermeneutic circle of investigating a person’s experience is therefore viewed within IPA as the route to understanding the essence of the person’s experience.

The associations between IPA and its philosophical foundations provides evidence of its particular view of knowledge, and ways of interpreting phenomena in order to gain an understanding of the essence of a phenomenon through the particular moments of description, meaning, and comprehension within the experience. This philosophical basis therefore centres on the conscious awareness of experiences within the lived world of the individual. However, as a qualitative approach IPA developed within the human sciences and occupies a research position acknowledging but extending beyond philosophical discourse to encompass a wider epistemological

framework in the investigation of psychological experience. In taking this position, Smith et al. (2009) utilise the philosophical ontology of existence and knowledge to understand an individual's meaning-making and experience of their relationship to their world. Within IPA it is the meaning and sense making through reflective interpretation which is essential to the methodological approach and so locates IPA experientially but also in alignment with a social-cognitive framework. As Smith et al. highlight, the ability to reflect on experience from multiple layers of awareness of an experience is a cognitive process involving memory, attention, and crucially meaning making. In this regard, IPA offers psychology an important methodology which integrates multiple layers of experience through an inductive process centring on "the value of complimentary micro analyses...which may enrich the development of more macro accounts" (Smith et al, 2009, p. 202). Applebaum (2012) emphasises how important it is that the findings from individual cases should inform the wider 'horizon' of scientific understanding. In this regard, IPA offers an integration of the many aspects of phenomenological experience grounded in the individual experiences of participants, but also acknowledges how these findings relate to the wider theoretical positions in the development of psychological knowledge.

The philosophical and epistemological foundations of IPA therefore inform a methodology suitable to exploring the lived meanings of people and their interpretations of their experience. As Larkin, Watts, and Clifton (2006) emphasise, IPA represents a flexible approach suited to giving voice to the participants' own experiential claims and offering a *person-in-context* understanding of meaning that locates individual experience in relation to the lived world. The research aims of this study set out to explore the individual meanings and interpretations participants have of their experience of PTG and of the role of the therapeutic relationship in facilitating PTG. Given the central role IPA offers with its focus on meaning and accounts of lived experience, IPA was therefore chosen to provide the methodological context best suited to examine these participant experiences.

### **3.2. Participants**

#### **3.2.1 Sampling and recruitment.**

##### **3.2.1.1 Sampling.**

A purposive sample of seven participants who had been treated for PTSD using EMDR therapy were recruited to the study. The purposive sampling allowed the participants to be drawn from a homogeneous group who had experienced trauma symptoms to the extent of receiving a diagnosis of PTSD and who had received EMDR treatment for their difficulties in the past year.

The participants were approached to consider taking part in the study following completion of their EMDR treatment within one of three NHS psychological therapy services in the West Midlands.

##### **3.2.1.2 Recruitment.**

The participants were recruited through the NHS Primary Care Psychological Therapy Service who had provided EMDR therapy to them in the past year for their trauma-related difficulties.

Participants were assessed for inclusion in the study by the therapist following the inclusion and exclusion criteria. Those individuals who met the criteria for PTSD and had completed treatment for their condition in the past year were then approached by their therapist for involvement in the study. The researcher was not directly involved in the initial contact for recruitment as this was carried out by the participants' therapist who acted as gatekeeper to the study. The therapist contacted the participant either in person at the end of their therapy or by telephone and subsequently the participants were provided with the therapist's and researcher's introductory letters, research information sheet, and consent form (Appendices 2-5). Participants

were provided with the opportunity to contact the researcher for further information regarding the research before contact from the researcher. After reading the information sheet and agreeing to take part in the study the participants were then asked to complete the consent form and either return this to the researcher's supervisor or give it in person to the researcher at interview.

Following their agreement to participate they were contacted by the researcher to arrange a suitable time and venue for the interviews to take place at either an NHS Primary Care treatment setting within confidential clinical rooms or a location of the participant's choice.

### **3.2.2 Inclusion and exclusion criteria.**

#### **3.2.2.1 Inclusion criteria.**

- (a) Aged eighteen or over
- (b) A score of >33 at therapist assessment for EMDR on the *Impact of Event Scale-Revised* (IES-R: Weiss & Marmar, 1997)

The IES-R is administered within the psychological therapy services involved in the study to provide a clinical diagnosis of PTSD in conjunction with clinical assessment. The IES-R is a 22 item questionnaire measuring how much distress the participant has experienced to a particularly traumatic life event they identify as their key concern. This distress is measured across three subscales of hyperarousal, intrusions, and avoidance which is in line with current symptomology measures of Posttraumatic Stress Disorder as outlined in the Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-V, American Psychiatric Association, 2013). Participants complete a five point Likert scale from 0 (Not at all) through to 4 (Extremely) for each item with an overall range of 0-88. A score of 33 represents the cut off point for a clinical diagnosis of Posttraumatic Stress Disorder. Beck et al. (2008) report a recent study into the validity of the IES-R which rendered a Cronbach alpha of .71-.86.

(c) Clinical assessment of PTSD through administration of IES-R.

(d) Received EMDR treatment for PTSD within an NHS Primary Care Psychological Therapy Service within the past year.

(e) Experience of PTG as indicated by a score of  $>54$  on the *Psychological Well-Being Post-Traumatic Changes Questionnaire PWB-PTCQ* (Regel & Joseph, 2010).

The PWB-PTCQ is an eighteen item self-report questionnaire designed to measure changes in psychological well-being following traumatic events. It measures change across the domains of self-acceptance, autonomy, purpose in life, relationships, sense of mastery, and personal growth. In covering these domains it reflects recent evidence relating measures of PTG in association to psychological well-being as distinct from subjective well-being (Durkin & Joseph, 2009). Additionally, the PWB-PTCQ measures both positive and negative changes on a Likert scale. Scores are collated giving a range of 18-90 with scores over 54 representing positive change. The scale has shown internal consistency across three sample groups including two general population samples and a trauma population sample of 254 participants providing a Cronbach alpha  $>.87$  (Joseph et al., 2012). The measure also demonstrated concurrent and discriminant validity with the The Posttraumatic Growth Inventory (PTGI: Tedeschi & Calhoun, 1996), and the Changes in Outlook Questionnaire (CiOQ: Joseph, Williams, & Yule, 1993).

### **3.2.2.2 Exclusion criteria.**

In-line with the exclusion criteria of the participating services the following criteria were set:

(a) Participants with a diagnosis of psychosis or who are exhibiting psychotic symptoms.

(b) Participants with severe cognitive impairment inclusive of deficits in memory.

- (c) Participants with current serious self-injurious behaviour or currently at high risk of suicidal or homicidal behaviour.

Current treatments for PTSD have narrowed their exclusion criteria in line with research evidence so providing assistance to a wider set of individuals. However, due to the cognitive processing elements of the trauma treatments the above exclusion criteria are maintained in order to reduce potential risks to the individuals concerned (Foa, Hembree & Rothbaum, 2007).

### 3.2.3 Participant details.

Table 1. below outlines the characteristics of the participants involved in the study. Six of these participants were female ( $n=6$ ) and one was male ( $n=1$ ). Their ages ranged from 32 years to 53 years and two participants were in a current relationship with five being single or divorced. The participants' traumas were mainly of an interpersonal nature including sexual assault, domestic violence, physical and psychological abuse, with one participant experiencing traumatic bereavement.

**Table 1. Participant demographics, therapy completion and trauma type**

<b>Participant</b> (Pseudonyms used throughout)	<b>Age</b>	<b>Gender</b>	<b>Relationship status</b>	<b>Date completed therapy</b>	<b>PWB-PTCQ Scores</b>	<b>Trauma type</b>
Liz	53	Female	Married	Sept 2015	79	Sexual assault
Susan	36	Female	Single	July 2015	80	Sexual assault
Linda	44	Female	Single	Sept 2015	87	Domestic violence
Sally	48	Female	Divorced	Dec 2014	69	Sexual assault
Jackie	50	Female	Co-habiting	Nov 2015	83	Sexual assault
Adele	32	Female	Single	August 2015	83	Traumatic bereavement
Tom	50	Male	Single	Dec 2014	74	Physical and psychological abuse



### 3.3. Interview Schedule Development

A semi-structured interview schedule was developed for the research in order to provide what Smith, Flowers, and Larkin (2009) term a ‘sideways’ approach to the research aims. With this semi-structured approach, Smith et al. highlight how the effect of the open-ended questions aids the participants in exploring their own lived experiences of the phenomenon under investigation. A copy of the interview schedule can be found in Appendix 6.

The development of the interview schedule questions was informed by the extensive literature review which led to a number of key formative areas being identified in order to explore the aims of the research. These formative areas included:

- What were the participants’ experiences of coping with their trauma prior to seeking psychological therapy?
- How did they experience any positive change during their EMDR therapy?
- What were the participants’ experiences of the therapeutic relationship as they went through their EMDR therapy?
- What were the participants’ experiences of working with their therapist as they went through their therapy?
- What were their experiences of the role of the therapeutic relationship in any positive changes they experienced during their EMDR therapy?

Nine main open-ended interview questions evolved from these areas noted as important through the literature review. Research into the facilitation of PTG during therapeutic interventions has focused on pre- and post-therapy experiences to examine the facilitation of PTG from a quantitative perspective. The present study was similarly considering PTG but in terms of the participants’ phenomenological experiences and the importance of the therapeutic relationship to

these experiences. It was felt that gaining participants' understanding of their coping prior to their seeking psychological therapy would help to benchmark any subsequent interpretations they made of positive change as they engaged in their EMDR therapy. An initial question was therefore constructed on the interview schedule regarding participants' views on the reasons for seeking help and their prior coping.

The second area of development for the interview schedule concerned the participants' phenomenological experience of PTG as they underwent their EMDR therapy. The literature review noted a paucity of research relating to the lived experience of PTG during therapeutic intervention and particularly during EMDR therapy. A criterion for inclusion in the study was evidence of PTG from responses to the PWB-PTCQ questionnaire. However, in order for participants to explore their lived experience of PTG during their EMDR therapy it was felt that open-ended questions around experiences of positive change on the interview schedule would provide participants with the opportunity for this further exploration of PTG.

The literature review identified the potential importance of the therapeutic relationship in trauma-focused treatments for the emergence of PTG. Consideration of this was also taken into account during the development of the interview schedule. The subsequent open-ended questions regarding the participants' experience of working with their therapist provided the opportunity for the participants to explore the experiences of the therapeutic relationship in relation to their EMDR therapy and PTG.

The final formative area identified from the literature review which influenced development of the questions on the interview schedule concerned the role the therapeutic relationship may have in facilitating PTG. This led to a question on the interview schedule considering participants' understanding of any factors involved in their therapeutic relationships that may have been important to the emergence of any positive changes they experienced.

In this process of developing the semi-structured interview schedule from the formative questions that emerged from the literature review, the open-ended questions provided participants with a *phenomenological map* during the interview to allow them to begin exploring their own lived experiences of PTG and their EMDR therapy. In addition, the funnelling of questions across the interview schedule allowed participants to provide narrative across their whole therapy experience, whilst being careful not to prime the participants during the interview (Knox & Burkard, 2009).

Kvale and Brinkman (2009) emphasise how the research interview does not represent a conversation between equal partners because the researcher defines and controls the situation. However, in following Smith, Flowers, and Larkin's (2009) approach to interview question construction, it was felt the research provides the participants with a series of open questions that would provide a flexible context for them to begin exploring their own experiences as they engaged in their EMDR therapy.

A series of sub or prompting questions were also created for each main interview question in order to aid exploration of the participants' experiences. These questions were structured by the researcher following the phenomenological map and were checked for appropriateness with the supervisory team and in ethical review. Following engagement with the NHS Research Ethics Committee, an additional question was suggested by the panel as useful to help the participant's explore how they experienced their therapist within the therapeutic relationship. This additional question was therefore incorporated into the agreed semi-structured interview schedule.

### **3.4. Interview context**

The participants were provided with the option of attending their interview either within a therapeutic room at an NHS venue or at a location of their choosing. For some participants, the therapeutic setting was the one in which they had received their treatment. For others, it was a similar therapeutic room in the psychological therapy service setting. Both options of NHS setting or other participant chosen venue were provided to the participants in order to allow some familiarity with the setting. It was also felt that providing participants with this choice would provide a sense of personal control to help to address any potential imbalance of power that can exist around the setting of the research interview. All participants took up the option of the clinical treatment setting. Given that participants had been acquainted with these settings during treatment, it was felt that this would provide further reassurance through familiarity with the process of attending and entering the building.

Further contextual consideration was given to the interviews with regards to the relationship between the interviewer and interviewee. The researcher aimed to provide a relational environment where the participants felt respected and comfortable so as to be able to talk openly about their experiences. This also involved the researcher being able to manage his own emotional reactions invoked in the recounting of the participants' traumatic experiences, so allowing the emotional security necessary for participants to elaborate on their experiences (Knox & Burkard, 2009).

Recognition was given to the potential imbalance of power in the setting of the interview as described but also during the dialogic encounter between interviewer and interviewee during the research interviews. In order to help address any potential imbalances, the researcher aimed to promote a non-judgmental openness in dialogue with the participants through curious but sensitive exploration of the participant's experience. Additionally, acknowledgement and attentiveness was

given to the participants' own ability to explore their experiences in their unfolding narratives and interpretations.

The recounting of traumatic life experiences in the context of a research interview represented an important ethical consideration in designing the interview study as noted in section 3.8 of this thesis due to the potential for retraumatisation. However, research has demonstrated that being involved in research interviews about past traumatic experiences can represent a positive experience for participants rather than necessarily having an adverse effect (Buckle, Dwyer, & Jackson, 2010; Legerski & Bunnell, 2010). The emerging narrative of the participants during their interviews in the present study highlighted how the process of engaging in the interview process itself represented a positive experience for the participants. Their exploration of the positive life changes they had experienced suggested a sense to the researcher within the interview room that the process of interpreting, naming, and exploring these changes provided a deepening phenomenological acknowledgment and understanding of the quality of change they underwent during their EMDR therapy.

The potential positive benefit to the participants of engaging in the research interviews also paralleled benefits to the researcher during and after the interviews. The researcher realised during the interview process the extent to which the qualities and presence of the therapist are perceived by the participants as key to engagement in therapy and to the fostering of positive change.

In contrast, hearing graphic accounts of interpersonal trauma represented a possibility for distress in the interviewer too. Preparations for this were in place if required through confidential supervision arrangements for the researcher. However, the interview experience did not lead to any distress for the researcher and the process resulted in a further positive impact. The intersubjective witnessing of accounts of positive change following such traumatic events brought a deeper awareness to the researcher of the fortitude of individuals to not only address their symptoms of distress, but to experience positive changes despite such traumatic adversity. As Calhoun and

Tedeschi (2013) have highlighted, PTG can occur for individuals experiencing adversities but also vicariously to those who witness accounts of positive change during trauma-focused work.

### **3.5. Procedure**

Following favourable ethical review from the NHS Research Ethics Committee and The University of Wolverhampton ethics committee, participants were recruited as outlined above in section 3.2.1.2 and informed consent was provided by them. Participants were invited to attend their interview within a clinical setting or at a location of their choosing. During the initial meeting the participants were again asked if they had understood what involvement in the study entailed and given the opportunity to ask any further questions about the research. If they consented to take part they provided the researcher with the signed consent form. Participants were then asked to complete a demographics sheet including the client's contact details, age, gender, relational status, therapy end date, and anonymising self-coding procedure (Appendix 7). In order to take a measure of participants PTG, the Psychological Well-Being Post-Traumatic Changes Questionnaire (PWB-PTCQ) was then administered to the participants prior to the interview commencing. (See Appendix 8).

The participants were then familiarised with the interview procedure and the positioning of the recording device and asked if they wished to continue. Narrative accounts were then recorded with the interviews ranging from between fifty-six and seventy-seven minutes in duration.

At the end of the interviews the participants were thanked for their involvement and they were provided with a debriefing sheet (Appendix 9) explaining the purpose of the study to them, and providing them with information voluntary and statutory agencies to contact should they feel they required any further assistance. There was a brief discussion concerning their experience of the interview to ensure their emotional well-being and to ask if they wished to receive a copy of the study's summary findings.

Participant information was then stored securely in line with data protection procedures as laid out within the University of Wolverhampton and agreed through the Black Country NHS Research Ethics Committee. The recorded interviews were transcribed by an employee of the University of Wolverhampton recommended by the research supervisor and all data protection procedures were adhered to within this process. A transcription key describing notation and substitutions to preserve anonymity and confidentiality can be found in Appendix 1.

In order to meet the NHS further duty of care towards the participants, and following informed consent being given by them on the consent form at the outset of the research, each participant's doctor was informed by letter of their patient's involvement in the study. A copy of the GP letter can be found in (Appendix 10).

### **3.6. Data Analysis Process**

The analysis of the participant interviews followed the guidelines described by Smith, Flowers, and Larkin (2009) providing an in-depth analysis of the participants' individual accounts of the meanings and experiences during their therapy. The initial phase of analysis involved the researcher listening to the first audio recording in conjunction with an initial reading of the transcription of the recording. As the transcriptions were read, initial notes were made in the researcher's research notebook regarding overall impressions from the flow of the interviews to provide a contextual understanding of the interview for the researcher and his relationship to it. This allowed a reflexive noting of the researcher's own impressions so as to begin the reflexive acknowledgement of the researcher's own impressions and return attention to the participants own lived experience within the accounts.

A deepening of engagement with the participant accounts then commenced with an exploratory reading of the transcript data and noting of impressions and comments on the data. Smith et al. suggest that analysis at this stage takes the form of three levels of comments:

descriptive content, linguistic style used by the participant, and conceptual interrogation. These comments or meaning units were entered into a three-column tabularisation of the transcript to assist analysis where comments were placed next to the text with interpretation moving from left to right as analysis progressed. An example of this second stage of the process can be seen in Appendix 11. As analysis proceeded, the researcher continued to check his comments for any influence from his fore-structuring and utilised the hermeneutic circle to iteratively move between text and analysis to ensure the trustworthiness of the comments. The researcher developed a system using an erasable whiteboard to provide a visual representation of his fore-structuring and the emerging meaning units to provide the necessary awareness to bracket out theoretical assumptions from any analysis at this second stage of analysis. A photo of the researcher's whiteboard can be found in Appendix 12.

The third stage of the analysis then involved considering emergent themes within the textual comments made on the participant's transcript. Here again an aspect of the hermeneutic circle became important with the representative parts of the participant's dialogue being brought to a wider holistic understanding at the thematic level of interpretation. These emergent themes were then noted in the right-hand column of the tabularised transcript an example of which can be seen in Appendix 13.

The fourth stage of analysis involved clustering the themes according to conceptual relationships, differentiation, or patterns of meaning where temporal, contextual, or valenced qualities of the participant's themes assisted the development of superordinate themes. The researcher used a word document to group each individual participant's themes and an example of this can be seen in Appendix 14. The researcher also utilised the researcher's whiteboard to begin this clustering of thematic content across the participants, see Appendix 12.

The fifth stage involved moving sequentially through each participant's interview and repeating stages one to four whilst bracketing off awareness of the themes already identified within



each previous case so as to allow each new participant analysis to present itself on its own merits within the interpretative process.

The superordinate themes across all participants were then compared in the final stage of the analysis again moving in the hermeneutic circle from the specific to wider understanding of the emergent themes. As Smith, Flowers, and Larkin (2009) suggest, it is at this point that theoretical understanding can aid interpretative convergence whilst ensuring that this convergence is located within the content of the individual participant's understanding of the concepts. In order to further validate these higher order relationships, a spreadsheet was produced to locate the shared superordinate themes, sub-themes, and example text from each participant (See example Appendix 15).

### **3.7. Trustworthiness, Quality, and Reflexivity**

In carrying out a qualitative research study using IPA it is important to consider the co-construction of knowledge and understanding as the researcher brings their own experiences, assumptions, values and ways of relating to the interpretation of any given phenomenological experience of a participant (Langdridge, 2007). Langdridge describes the influence a researcher's assumptions can have on the qualitative research process from the initial decisions in choosing the research topic and research questions, through to the design, methodology, and analysis of participant data within the research study. Given this potential influence that a researcher can have on biasing the research at many points during its inception and completion, it is important that strategies to ensure trustworthiness and research quality are provided throughout the research endeavour.

In order to provide the quality and trustworthiness of the research process and findings, the researcher employed reflexive and bracketing processes during the planning, implementation, and

interpretive analysis stages of the study. Willig (2013) has highlighted how having awareness of fore-structuring of knowledge, experience, and professional and personal positioning in relation to the research, provides the researcher with the opportunity to reduce the influence of their existing assumptions at the theoretical, clinical, or personal level.

As a trainee Counselling Psychologist, I approached the research from a background where an integrative approach of humanistic, person-centred, and cognitive-behavioural therapeutic practice had shaped my positioning both as a practitioner and a researcher. I was therefore mindful to acknowledge the therapeutic lens through which I approached the research. Underlying this therapeutic position was a belief in the phenomenological lived experience as meaningful to the individual and so I acknowledged my positioning and engaged with the design and analysis of the research from a reflexive position holding my own therapeutic influences within awareness.

The therapeutic approach examined in the current study involved EMDR therapy. I had worked alongside a number of EMDR therapists in my previous clinical role and was aware of the basic underlying tenets of the approach. However, this was an approach that I had not trained in and as I planned the research study, and engaged in the phenomenological analysis, I was mindful of my fore-structuring and limited understanding of the process and protocol factors of EMDR. Despite the limitations in my depth of understanding of the EMDR approach, I felt that my interpretive stance during the analysis of the findings would benefit from my *disciplined naiveté* by preventing an over-identification with the therapeutic approach studied (Giorgi & Giorgi, 2003). The interpretation of meaning would therefore emerge through a closer alignment with the participants' own experiences rather than being overly influenced by specific therapeutic assumptions and pre-existing knowledge.

The reflexivity around fore-structuring and the hermeneutic circle also extended to my personal relationship to the research area. Approaching the research at the personal, human level, the research area was one that had some significance to me through my professional and personal

life. I had seen individuals experiencing traumatic events and so was aware of both the salutogenic and pathogenic outcomes that could occur for people. In my own life I have not experienced life events to the extent of extreme adversity but, for any human being, life presents challenges and traumas and so in this general regard I acknowledged both being an outsider to trauma *in-extremis*, but also having been an insider in witnessing the impact of this depth of emotional distress and life transformation. As Clarkson and Angelo (1995) emphasise, as researchers we are also storytellers telling the participant's story through our own eyes and so the importance of recognising who I am as a storyteller is of vital significance to maintain the validity of the participants' storied world. Given the awareness of my positioning to the research, the use of my reflexive analysis within my research journal was an important part of regularly and reflectively *checking-in* with my own assumptions as I planned, implemented, and analysed the research.

The checking-in process noted above represented a reflexive ability to hold, or *bracket*, my fore-structuring whilst interpreting the sense-making attempts of the participants. The bracketing process was undertaken in order to ensure that the researcher's own fore-structure of knowledge and presuppositions were acknowledged as potential influences on the analysis and were held in awareness during the hermeneutic circle of interpretation.

Heidegger (1927) noted how interpretation and meaning emerged not through objectively isolating the observer from the phenomenon but through the relationship between the phenomenon and the individual in an interpretive hermeneutic circle. From this perspective, it is only during the interpretive process itself where the interpreter engages with phenomenon by, "bracketing pre-understandings and exploiting them as a source of insight", that fore-structuring can itself add to the depth of interpretive validity (Finlay, 2008, p. 1). Within this study, the use of reflexive journaling and the researcher's reflexive whiteboard technique were employed to provide this *dual role* or interplay between the bracketing of fore-structure and the identification of emergent meanings in the participants' narrative during the hermeneutic circle of interpretation. This bracketing process

added further commitment and rigour to the interpretive process by acknowledging and holding constant in awareness the influence of the researcher's own presuppositions, whilst allowing the co-constructed meanings to emerge from the participant's own accounts of their lived experience (Fischer, 2009).

Rigour and trustworthiness have been demonstrated to be of vital importance for the researcher conducting a qualitative research study (Elliott, Fischer, & Rennie, 1999). The current study recognised the need to provide a framework to the methodological approach and evaluation of the participant experiences which would aid trustworthiness in the study's findings. Consideration was given to current conceptualisations of the criteria believed to inform trustworthiness. The researcher's approach to the inception, design, and analysis of the current research followed a set of quality criteria proposed by Yardley (2000, 2008). Yardley describes four key criteria areas involving an emphasis on being *sensitive to the context* of any phenomenon examined, *the commitment and rigour* of engagement in the research process, *transparency* of the data analysis and *coherence* of the design and findings of the study, and the subsequent *impact* and *importance* in presenting the findings.

The decision to align the research to the trustworthiness criteria set out by Yardley (2000, 2008) followed consideration of other quality criteria, particularly those emphasised by Lincoln and Guba (1985) of *credibility*, *dependability*, *neutrality*, and *transferability*. In examining these criteria, the researcher found convergence with Yardley's description of trustworthiness at a theoretical level but the operational definition of Yardley's criteria suggested a closer fit to the research aims of the present study.

The emphasis given by Yardley (2000, 2008) to sensitivity to socio-cultural contexts suggested a refinement to this area of trustworthiness which extended beyond the *prolonged engagement* with context proposed by Lincoln and Guba (1985). The theoretical review of PTG noted in this study highlighted the importance of contextual factors in the experience of PTG

including the socio-cultural context of the participants' traumatic experiences, and the potential importance of the therapeutic relationship for facilitating PTG. Yardley's emphasis on context therefore suggested a good fit to the study's aims where consideration of the intersubjective *context* of the therapeutic relationship was to be explored in relation to experiences of PTG. It was also felt that Yardley's wider trustworthiness criteria matched well to the IPA methodology where the *commitment* and *rigorous* depth of analysis would allow participants' meanings associated with their lived experience of PTG to be fully explored and articulated. The *coherence*, *impact*, and *importance* proposed by Yardley provided further convergence with the present psychological research through acknowledgment of the participant voice to provide insights that could have future clinical utility within applied psychology (Swanson, Durham, & Albright, 1997).

The refinement in operational definitions by Yardley (2000, 2008) therefore appeared to be progressive in promoting trustworthiness and wider validity demonstrating what Lincoln and Guba (1986) emphasise as a need for continual criteria development in qualitative research with "concomitant attempts to put those axioms and procedures into practice" (p. 83).

Triangulation by peer-review and member-checking is a further process through which trustworthiness of research findings can be strengthened (Willig, 2013). Within the present study, peer-review was carried out during interpretive analysis where sample transcripts were presented to the research supervisor for comparative consideration of emerging themes. This process was employed to give an additional check to the reliability of the researcher's analysis of emerging themes.

Lincoln and Guba (1985) have suggested that member checking is crucial to the validity of research findings where participant feedback is sought on the findings of the researcher's analysis. However, Mason (2002) suggests that the recourse to this wider participant feedback may not always be helpful to interpretive analysis due to the potential for participant *post hoc rationalisation* or suppression of meanings. From this perspective, the implicit meaning embedded in narrative may

not be readily available to interpretation by the participants depending on their level of ability to engage with the interpretative depth of analysis required. Consideration was given to these ambiguities regarding the benefits of participant verification but other factors also informed whether the inclusion of this additional level of checking would be required. Yardley (1997) states that the reality of real-world qualitative research can involve constraints on time, cost, and access in organising the research, and so it is important to be “sensitive to the complexities and practicalities of professional endeavour” (p. 44). Given the pragmatic time constraints of the research project, an adherence to a transparent hermeneutic analysis with robust commitment to reflexivity, and recourse to a peer-review process, it was decided that further additional member checking would not be implemented in the current study.

### **3.8. Ethical Considerations**

Confidentiality and anonymity were of key importance in the design, implementation, and dissemination of the research study and followed the British Psychological Society (2010) ethical research guidelines where participants’ anonymity and confidentiality are maintained and respected. All names and identifying information within transcripts and within the body of this thesis were replaced with pseudonyms or were retracted with substitutions to ensure anonymity. (See Appendix 1 for key to transcription substitutions).

Ethical approval for the research was sought from the University of Wolverhampton’s School of Applied Sciences Student Management Board, and the Behavioural Sciences Ethics Committee which both granted permissions for the research to be implemented following clearance from the NHS Research Ethics Committee (NREC) (See Appendices 16 & 17). The research proposal was submitted to the NREC and approval for the research to go ahead. (See Appendix 18). An amendment to the research proposal was made to the NREC in December 2012 to focus the research on the qualitative investigations only and this was approved in February 2015 (See Appendix 19).

The research followed all ethical guidelines and practice with regards to informed consent where participants were provided with a comprehensive research information sheet outlining the research study and ethical safeguards. (Appendix 4). The participants were also provided with the opportunity to discuss the research with their therapists who acted as gatekeepers to the research prior to contact with the researcher so providing further information before providing informed consent. Participants were informed of the right to withdraw from the study at any point during the study and were provided with a consent form. (Appendix 5).

The researcher was fully aware throughout the study of the ethical guideline on doing no harm to research participants. Given that the research concerned the potential for patients to discuss sensitive issues around their traumatic life events and their psychological therapy then additional safeguards were made. They were informed in the information sheet of the potential hazards from participation but also the provision of additional psychological support both from the psychological therapy services they had been engaged with and also wider sources of mental health support in the community should this be required. This additional support was agreed with the NHS Psychological Therapy managers involved in the study. During the interview phase of the study the researcher was additionally mindful to monitor the participants' reactions within the interview to ensure no harm or distress to the participant (Smith, Flowers, and Larkin, (2009) Throughout the interviews the researcher aimed to be respectful, authentic and develop rapport in his initial contact with the participants to ensure they felt comfortable in the interview setting.

All participants were provided with the contact details of the NHS Patient Advice and Liaison Service should they wish to know more general information about engaging in research in the NHS.

## **Chapter 4: Findings**

### **4.1. Data Analysis**

Following the interpretative analysis of participants accounts of their experiences during their EMDR therapy, four superordinate themes emerged from the data as detailed in Table 1:

**Table 1. Superordinate and sub-themes.**

<b>Superordinate themes</b>	<b>Sub-themes</b>
4.1.1 Safe and secure	4.1.1.1 <i>Allaying uncertainty</i>
	4.1.1.2 <i>Comfortable and at ease</i>
	4.1.1.3 <i>Professional and knowledgeable</i>
	4.1.1.4 <i>Developing trust</i>
4.1.2 Taking back control	4.1.2.1 <i>Managing emotions</i>
	4.1.2.2 <i>Reconnecting with life</i>
	4.1.2.3 <i>Empowering control</i>
4.1.3 Reconstructing the self	4.1.3.1 <i>Recognising strengths</i>
	4.1.3.2 <i>Reappraising responsibility</i>
	4.1.3.3 <i>Newfound self-worth</i>
	4.1.3.4 <i>Self in relation to others</i>
4.1.4 Journeying beyond trauma to the future	4.1.4.1 <i>Hidden behind locked doors</i>
	4.1.4.2 <i>Reprioritising the future with family</i>
	4.1.4.3 <i>Reprioritising future goals</i>



4.1.4.4 *Letting go of the past to move  
to a future with compassion  
and acceptance*

4.1.4.5 *A journey through therapy*

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These themes and sub-themes will each be explored in turn. Line numbers are denoted in parentheses after each quote and refer to the individual transcripts (see confidential attachment).

**4.1.1 Superordinate theme: Safe and secure.**

Many of the participants had experienced situations where they felt extremely unsafe, threatened, and fearful. This superordinate theme explores how their experience of being safe and secure was meaningful to moving past their trauma. Encapsulated in this overarching theme were sub-themes of: allaying uncertainty, comfortable and at ease, professional and knowledgeable, and developing trust.

**4.1.1.1 Sub-theme: Allaying uncertainty.**

Participants experienced feelings of doubt, uncertainty, and confusion at the start of therapy concerning their understanding around their responses to their traumatic experiences, what the actual therapeutic experience would involve, and trepidation about working with their therapist.

Having been through traumatic experiences many of the participants had been left confused about their trauma reactions and had taken their struggles to cope with the trauma as reflecting a personal sense of failure. Initial stages of therapy involved reconceptualising this response as 'normal' through the explanation of the trauma response as neurological process. Jackie and Linda described this process:

*And it wasn't a failing that you, because you're a weak person, it was that your brain was actually doing its job.*

(Jackie: 368-369)

*it made me understand that it is just the way my brain had processed, or not processed what had happened, rather than me as a person.*

(Linda: 87-88)

The normalising of trauma responses by the therapist helped Jackie and Linda gain 'reassurance' (Jackie: Line 363), and shift an appraisal of their trauma reactions as resulting from a perceived failing as a person, to one based on the neurological understandings of trauma.

The participants' therapists assisted in alleviating uncertainty about the actual therapeutic processes involved in EMDR through their socialisation to the protocol. Sally's account captures this sense of gaining clarity and understanding in her therapist's explanation about:

*how the EMDR therapy works, that it's to try and help to reprocess and reorder these memories in the brain and make it sort of safe... (800-801)*

Within these early interactions within the therapeutic relationship between participant and therapist we not only see moves to providing understanding in the therapeutic rationale but a developing sense of safety and security. This 'setting the scene' (Adele: 661-662) is therefore a crucial experience for participants as they begin their journey through the treatment.

Participants described the importance of working with their therapist and the qualities within the therapeutic relationship itself which helped them to move from anxiety and caution to a feeling of safety where they could open up emotionally.

Susan described her initial doubts and anxieties in starting out with her male therapist:

*To start off with I was nervous, erm, I kinda held back slightly...because I didn't know how he, what type, how he was gonna work with me or how I was gonna work with him... you know, what the relationship was gonna be like. (716-721)*

Susan highlights a sense of caution at the outset of starting her therapy but emphasises the importance for her of the relationship itself within her therapy. Given that her traumatic experiences had centred on two sexual assaults by males, it was understandable how she would have been hesitant and uncertain at the outset of her therapeutic relationship with a male therapist.

Sally echoed these anxieties and described how her male therapist, Mark, demonstrated a sensitivity to this experience by asking her whether she was '*okay with having therapy with a man*' (570-571) and subsequently valued the experience of working with him as a '*positive male role model*' (583). For Sally, working with a male therapist represented a progression for her in confronting her fears, as she pointed out to her therapist, '*five years previously...I don't think I could have coped with it*' (572-574).

For other participants, such as Tom, the change from previously having seen a female therapist to his current male therapist was an important move and allowed the development of safety, as he emphatically stated about working with a man this time, '*he was great, he was great*' (220-221).

The gender of the therapist was more central to other participants' needs within their EMDR treatment, as Jackie (420) pointed out she was '*so relieved*' to be working with a female therapist given her assault by a male.

Linda highlighted the importance to her of having a female therapist and what this provided for her:

*and to actually have somebody that I could share that with, and know that she would understand that female vulnerability, in, you know, as a female... made me feel very comfortable opening up to her. (526-530)*

Linda's experience demonstrates the central importance of the therapist being comfortable and secure with the person of the therapist at these crucial early stages of the therapeutic process.

#### **4.1.1.2. Sub-theme: Comfortable and at ease.**

This theme concerned participants' experiences with their therapist as engendering the feeling of being comfortable and at ease with the therapist as they engaged in their therapy after an initial period of discomfort and uncertainty.

As the participants progressed through their therapy they were having to work through deep emotional hurts and this, understandably, did not feel comfortable to them. Susan shows how her therapist's presence and pacing helped through these difficult early stages:

*So he, I think he held back slightly, he didn't wanna push me too much, so he was going very slow with asking certain questions... because at the end of the day, I didn't feel very comfortable talking to him about my life experience of what had happened.... to start off with. Cos every time I mentioned it I was in floods of tears.*

(716-721)

Susan recognised the importance of the pacing and sensitivity of the therapist in *holding back* through early interactions given the emotional reactions she experienced as she began to talk about her trauma. She went on to provide a perspective on the importance of the

therapist's sensitivity and actions in providing a sense of comfort in order to emotionally open up:

*They've gotta be careful, with what they say, how they say it, because if that person suddenly goes 'Oh, no' and they're gonna clog up.*

(960-961)

Clogging up equated to an inability to open up within the therapeutic relationship in order to effect emotional expression and change. A question these accounts raise is therefore how this comfort is actually defined for participants as they engage in their therapy to bring about positive change. Susan initially associates this comfort with the pacing and sensitivity of the therapist. However, she goes further in considering the relational elements of the therapeutic relationship as essential where she perceived the relationship as *like they're your friend* where she felt that *'they know everything about you'* (1025-1030) and she got to know her therapist, and this allowed her to feel *'more comfortable and more at ease'* to *'just open up'* (1032-1033). Other participants explained this depth of relating with the creation of safety to openly explore their emotional experiences:

**Linda:** *Erm... erm, compassionate, and is it emp... empathic? Empathy? I felt that she got, you know, she understood, I just felt that she understood what I was trying to say. Erm...*

**Interviewer:** *So you said empathy...*

**Linda:** *Yeh. And compassion.*

**Interviewer:** *Compassion? Yeah. And that was important to you?*

**Linda:** *Yeh because it made me feel safe enough to erm, expose my vulnerabilities...*

(575-581)

This narrative suggests how comfort is defined by the therapist displaying compassion and empathy. However, underlying this is a deeper respectful understanding for the participant's lived experience which she further describes as an attentiveness in the therapist and a non-judgmental approach, '*I feel like I had all her attention when I was there*' and Linda did not feel '*judged*' (Linda: 657 & 598).

Feeling safe within the therapeutic relationship emerged as a key factor for the participants where sensitive and often distressing emotions attached to their trauma experiences could be explored openly. Jackie highlighted that as she processed the flashbacks from the sexual assault she had experienced, '*she gave you the, the safety if you like, of exploring that*', and being able to, '*explore that in a safe environment.*' (Lines 648 & 678)

Feeling comfortable and emotionally at ease with the therapist held an important experiential place in the participants' perceptions of being able to open up emotionally and verbally to their experiences, and in working towards recovery from their traumatic experiences. As the participant accounts attest, having this comfort and ease offered them a safety and security both with the therapist and more importantly to be emotionally and psychologically able to safely explore their intimate experiences.

#### **4.1.1.3. Sub-theme: Professional and knowledgeable.**

Participants recognised the way the therapist's approach added to their sense of safety through the *professional* and *knowledgeable* approach they demonstrated during the treatment. The importance of sitting opposite a professional and knowledgeable therapist, who was able to explain the technicalities of the therapy protocol, was shown to be important in developing a safe and secure setting to explore experiences:

*So yeah I think some, most of that relationship building and the way she, I suppose, held the sessions really and just enabled me to feel safe within that.*

(668-670)

In this extract from Adele's account she highlights how significant it was for her to have the conjunction of both the therapeutic relationship in partnership with the management of the EMDR protocol provided by the therapist. This conjunction of relational and technical elements thus leading to her sense of safety in working through her traumatic experiences.

Sally discussed the way she felt the therapist was caring for her to help her understand her experiences and rebuild herself psychologically:

*I think he was just so professional in what he did that... yes it's his job to give the therapy but it did make me feel that mentally he was taking care of the broken bits if you like of me, mentally, and helping me to understand them and piece them back together. (761-765)*

Sally's understanding of her therapist was of being professional but also demonstrated her views of an agentic quality to her therapist which provided security through the knowledge and care for her psychological wellbeing and recovery.

This translation of knowledge from the therapeutic protocol was important to all the participants, as Adele notes, 'Yeh putting it in a way that I could actually understand and I could engage with' (725-726). The therapist's interpretations not only provided participants with the ability to engage in the therapy but also provided the participants with a deep level of respect for their vulnerability as they discussed upsetting trauma memories and experiences:

*You know, these things happen, these things were processed, but she did it in a very professional fashion which allowed you your dignity. (Jackie: 778-779)*

#### **4.1.1.4. Sub-theme: Developing trust.**

The development of trust was set against a backdrop of trust in other people having been eroded by the interpersonal nature of the traumatic events that the majority of participants had experienced. For example, Liz describes the background to her trauma where she had experienced an abusive childhood and in adult life went '*from an abusive marriage, to another abusive relationship.*' (413). As she highlighted in her account:

*I think I'd just got to the point with everybody where I believed it's not a matter of if they're gonna snap, it's a matter of when they're gonna snap.*

(435-437)

This uncertainty of reaction and loss of belief and trust in others was further evidenced by Linda in describing the effects of her past relationships:

*...just by the pure nature of past relationships, you know, I left a lot of things unsaid, because, I didn't know what sort of reaction it was gonna evoke*

(583-584)

We see through these extracts the way these participants' sense of trust with others was precarious and undermined across their lives and relationships.

Other participants lost trust in their social and familial relationships during their trauma. Jackie describes how she lost touch with her family and how this apparent abandonment of her following her traumatic experiences added further stress for her, being experienced as '*a traumatic thing*' in itself (37).



Many participants had lost trust relationally. They did not open up to others in their social circle for fear of the other person not being able to *hold* and understand the emotions associated with their trauma, and also to protect others from upset. This served a mutual benefit:

*...you know sometimes people can be erm, get twitchy and upset and everything and you think 'Oh shit I've got to look after you now.'* (Jackie: 575-576)

This protection of other people extended to the therapeutic relationship:

*And I was here, and there was this bloke, doing his best, but, erm... part of me said 'Well no, why should he put up with it, why should he have to deal with this?'*

(Tom: 1035-1037)

The process of trusting and disclosing to the therapist was through the therapists' demonstration that they could *hold* client emotions. For Tom, the opportunity to express his feelings about his trauma was built on knowing that, '*the therapist kind of won't be embarrassed by or won't be shocked by it*' (991-992). For Jackie the therapist '*being comfortable in your distress*' was important to her in being able to lower her guard '*cos you're building trust aren't you*' (573 & 988). The therapist was important in providing this arena for her emotional growth through this sense of trust in the process of recovery that Jackie was going through. However, she gained further *holding* from her spiritual faith in God where she highlights the importance of having this sense of presence available to her, '*... erm,[sighs] you can just, just know that somebody is there and they're just...holding you.*' (177-180).

The sense of presence for Jackie appeared within her narratives as located both with therapist and in this extract with God. Many participants made sense of their therapists' actions as a caring presence located both emotionally and spatially in the therapeutic endeavour, '*Again it was that, it was just that feeling of somebody cares enough to be sat here with me when I'm feeling*

*broken.*' (Sally, 849-850). In the following extract Linda describes the important meaning her therapist had for her in allowing her to work through her traumatic memories:

*... and I was seeing it and smelling it and everything. But, but knowing that she was there, and erm emotionally holding my hand through it...I felt strong enough to get through it and by obviously travelling through the experience with her, with the vibrating pads, knowing that I was gonna come out of the other side of it, with a little bit of understanding of it and a little bit of erm, self validation, was quite it was quite important. But actually, just knowing that there was somebody else there talking me through it and stopping if I needed to and erm, actually listening to what I was saying ... and interrupting when I was getting too distraught you know, and with the tissues and what have you, having, being able to explain it to somebody who is impartial, erm... made it, erm, I suppose it made it easier to deal with*

(738-750)

For Linda the compassionate presence and attuned responsiveness of her therapist defined the therapeutic environment of trust, where she felt deeply '*heard*' (542). This provided the reassurance to work through her trauma safely in order to reach a change in her own self-validation about her experiences.

The inherent responsiveness, presence, and care demonstrated by the therapist therefore represented for many participants the therapeutic arena in which trust developed. This trust then in turn allowed the participants to safely explore and work through their traumatic experiences.

#### **4.1.2 Superordinate theme: Taking back control.**

##### **4.1.2.1 Sub-theme: Managing emotions.**

The participants described a growing sense of control and personal agency as they engaged in their therapy. Trauma had led many of the participants to experience the recognisable emotional reactions of fear and distress, or feelings of anger and self-blame inherent in their trauma reactions. Participants were confronting their emotional responses and learning to acknowledge and manage these in the safety of the therapeutic relationship.

In the following extract from Liz we see her growing confidence in being able to acknowledge and express her anger which she had previously feared doing because of the perceived emotional consequences to her of being overwhelmed:

*And Steve kind of... made me realise I was entitled to be angry but I didn't have to let it destroy me. And, just being able to voice out loud that yeh I was angry... and it has genuinely just changed my whole view of the world.*

(803-805)

It is through the therapist's acknowledgement of her emotional experiences that she begins herself to feel justified and safe in exploring this anger. In giving voice to her anger, we see Liz learning to regulate her emotions adaptively rather than fearing them and holding them back. This change also had the profound impact for her in changing her worldview, where she no longer felt threatened but was learning to cope with the emotional impact of her experience.

Linda echoed this ability to release her anger but in her case for the way her eight-year old self had been treated. This emotional expression played a crucial part for her beginning to acknowledge these long hidden emotions:

*Erm, I just felt like she was, as well as obviously the actual vibrating EMDR treatment, erm, I felt like I was, erm, emotionally having my hand held and*

*letting me know that it was okay to feel like that, it was okay to feel angry about how my eight year old had been, you know, let down.*

(439-442)

For Linda, her therapist played a central part in this emotion regulation providing ‘validation’ (457) to her emotions whilst also helping her to learn a new way of managing the emotions in order to, as she describes, ‘sooth my inner child’ (465-466).

#### **4.1.2.2 Sub-theme: Reconnecting with life.**

As the participants worked alongside their therapists they also began to demonstrate ways they had taken back control in relation to a reconnection with life:

*I got more confident in doing things, going places on my own, doing things by myself, I’m not always constantly asking people you know ‘Do you fancy going up town, I don’t want to go on my own?’ I’ll go up there on my own. I don’t even think twice about it.*

(250-253)

Susan here describes her changed confidence to engage in life again and she later discussed how this had extended to holidays with her children and visits to her family (498-503). It can be suggested from her narrative how these changes rippled out to her wider relationships allowing greater engagement not just for herself but for her children too. Alongside this relational change, Susan also demonstrates a growing responsibility for her own life with a change in her autonomy and sense of independence which contrasts with former post-trauma reactions.

Sally also describes being more engaged in life where her experiences of doing things on her own are described as a ‘biggy’ for her (335).

*Yeh I do because... erm... I've actually done a few things by myself that I wouldn't have done, things like going off to [town name] on my own...*

(327-328)

She begins to consider the process of how these changes occurred and how personally important they are for her:

*Because again I feel I've got the tools to sort of say 'Well actually I am allowed a life of my own, I need to do these things for my physical health, to help the pain I'm in'...but also mentally...*

(354-356)

In Sally's account we experience the significance of the change and she clearly feels she has the tools now to cope through the EMDR, but this leads to a question of where the therapist is positioned in this process. In her further account she shows this through the importance of her therapist with his ‘gentle encouragement’ in order to ‘push my own boundaries a bit.’ (831-832). Other participants also found the therapist to be important to their change in encouraging them in their desire to ‘get back into the stuff I like doing’ as Liz says, and ‘no longer just sitting in a corner anymore’ (602-606).

#### **4.1.2.3 Sub-theme: Empowering control.**

The theme of empowering control captured the participants' experiences where their therapists' actions provided the means for the participants to take control and agency for themselves. In the extract from Liz we are witness to this *giving over* of control by the therapist and Liz's tentative steps in taking ownership of her decisions:

**Liz:** *And if I sort of said 'Look, I'm not ready to go here yet he was 'Okay, fine'.*

**Interviewer:** *Yeah.*

**Liz:** *And he basically let me lead.*

**Interviewer:** *Yeh, he let you lead?*

**Liz:** *Which... took a bit of getting used to! [laughing]*

(338-342)

Her confidence to challenge the pace of the therapy was matched by the responsiveness of the therapist in allowing her the space to make these crucial decisions and she recognised his role in this change where, '*he was all the time reinforcing that I could lead.*' (480).

Susan also demonstrates this regaining of personal control for her. In her case she did not want to halt her therapy but took responsibility for continuing where she felt comfortable to go at the time:

**Susan:** *I made the choice, not to stop it.*

**Interviewer:** *Yes. So something about you having that choice?*

**Susan:** *Mmm.*

**Interviewer:** *Yeh?*

**Susan:** *It made me feel a lot better in myself, the fact that the choice was mine to make...*

**Interviewer:** *Mmm.*

**Susan:** *... not theirs.*

**Interviewer:** *No.*

**Susan:** *Erm, I've never been given that before.*

(920-928)

We see in Susan's extract that having the opportunity and choice in managing the therapeutic process is again a new experience for her too. She provided evidence of the route to this change in the quality of the relationship with her therapist. She felt that she and the therapist had 'clicked' (938-939) on a level where the comfort and security noted earlier in the analysis provided the emergence of her ability to make the choices without judgement.

For other participants, such as Adele, the therapeutic relationship offered her a context in which to see 'the bigger picture' (230) on her life situation. She explicitly describes how this changed perspective resulted from her feelings of taking control, as she states:

*...which was great. It was very, I was going to say the word 'empowering' but that's a bit cheesy isn't it... a bit more, I felt a bit more in control and a bit autonomous that I could say 'Well I've got this [profession] qualification'... 'this isn't the only option, for me'.*

(232-236)

Here we see the importance of the *taking of control* allowing Adele to move beyond her pre-therapy views and perspectives of what was important to her to now be able to consider wider life priorities which have more authentic meaning for her. Intertwined in this reprioritising is again a sense of her gaining her independence which offers her a further facet to her sense of increased personal control within her life.

### 4.1.3 Superordinate theme: Reconstructing the self.

The participants experienced a number of changes throughout their EMDR therapy in relation to their sense of self, and a changed sense of self in comparison to their pre-therapy experiences.

#### 4.1.3.1 Sub-theme: *Recognising strengths.*

For many participants the experience of working through their trauma led to changes in their views of themselves. There was a growing awareness of a stronger and more confident self, able to cope with the challenges of life and having moved past the traumatic experiences they had struggled with. Linda states the changes she experienced in her initial overarching comment, ‘... *erm, I think I just, I’ve just come out of it a completely different person*’ (164). Jackie similarly indicates her recourse to her strengths, ‘*your strength of character is there*’ (894).

As Linda reflects on how she has changed personally, she highlights the role of the treatment, and the role of the therapist talking through her emotional responses, as important to her change and validating of her emotions. She goes further in defining the changes more specifically as a change in her self-appraisal as a strong person. She questions herself as to whether this change has come through from within the therapeutic relationship by talking and naming the changes. Significantly, in the last line of this extract, she also shows us how there was personal agency in this change where *she* made herself change these self-beliefs:

*I’m a lot more confident in myself, just in general, because obviously you know, going through the treatment and you know ‘How did you feel about that?’ and to actually sort of like travel through and sort of say ‘Well I feel strong, I feel this’... it’s almost, validated, my feelings I suppose. That, that strength of*



*character...I don't know whether it's a placebo effect, or whether just sort of having to, you know, say you know, 'Yes I'm a strong person and I feel this'... it's, I suppose I made myself believe it.*

(166-178)

Linda's account highlights her experience of changes within her sense of self with these being at the cognitive or schematic level of self-belief. In her subsequent accounts she reflects further on how these changes came about, again emphasising them at a cognitive level as *thinking* differently and speculating on the EMDR process as having directly assisted in the changed view of self. Interestingly, this is described as a deeply profound change for her which is also embodied right inside her at the affective level as well as at the level of thoughts:

**Linda:** *And it's the whole sort of positive thinking...*

**Interviewer:** *Yeh.*

**Linda:** *... that I don't know whether the erm, the EMDR, the erm the vibrating treatments, as I was thinking that helps sort of like instil it into my brain or like I say whether it was a bit of a placebo effect and I think it's there, that I can now, I feel it as well as you know, I feel it right inside...*

(244-249)

For Linda the changes she experiences are intricately related to her sense of self and her self-belief but within these two accounts she also tries to pinpoint the cause of these changes. In the first extract she sees the intersubjectivity and dialogue between herself and the therapist naming the changes as potentially the route to her change, and in this second extract brings in the sense that possibly the EMDR technical elements themselves may be important to the change. Interestingly, in both extracts she juxtaposes these attempts at explanation of change with a placebo effect. In considering this, she hints to the role of expectations within herself as potentially implicated in the

reasoning behind her changed sense of self, which takes account of both the importance of the therapeutic relationship and the role of the EMDR treatment itself.

#### **4.1.3.2 Sub-theme: Reappraising responsibility.**

For several participants, an important factor in the move towards a changed sense of self was how they positioned themselves in relation a sense of blame and responsibility around what had happened to them. In this process we can see a change of perspective at a cognitive level but also at a much deeper intrapersonal conceptual level where the sense of self as *at fault* moves to a more adaptive and realistic interpretation of self.

Many participants noted their feelings of self-blame but then how this changed as they progressed through therapy. Susan discusses the self-blame she had held in relation to her trauma as she says she, '*was always doubting myself. Always blaming myself, that it was my fault*' (230-231).

Susan then relates how she now perceives the blame from a different perspective and highlights a developing acceptance that her counter-factual thinking is pointless and ultimately where she feels responsibility for her experience lies:

**Susan:** *No, it wasn't my fault. Yes, I could have done something different, but that's in the past now, I can't change it.*

**Interviewer:** *No.*

**Susan:** *But I know in myself that now one, it was not my fault, and two, that he's at fault, he's to blame.*

(233-237)

Reappraising this sense of responsibility, or belief of self-blame, provided a significant change for other participants too and particularly in the way it affected their sense of self. As Sally points out in her narrative of her insights around her changed self-responsibility:

*‘But I do feel more at peace with myself and with the past. It doesn’t mean I agree with what was done to me in the past, it doesn’t mean that I condone any of the actions that either that [person’s employment role] carried out or my ex partner. But, I feel much more at peace with it now....I feel less to blame.’*

(237-243)

The participants clearly demonstrate changes at their level of beliefs about responsibility in relation to them personally forged through their acceptance of what they experienced as not being right or justified. From their narrative accounts, understanding about how this change may have transpired within the therapeutic relationship were evident. The therapist was seen as central to Liz’s own self-challenge about the reality of responsibility. She describes the process of her changed beliefs around ‘fault’:

**Liz:** ... but *I think I still held the belief that I deserved it all.*

**Interviewer:** *Oh okay.*

**Liz:** *So, Steve made me, made me challenge why I believed I deserved it.*

**Interviewer:** *Yeh. So something about challenging it?*

**Liz:** *Made me sort of realise ‘Hang on, just because people say “Oh it’s your fault”, doesn’t mean it is’. You know I’m, like when I was a kid he made me realise that I had little say in what happened. I was sort of five, six, seven.*

(420-426)

In this extract we see Liz reappraising her experience of others’ *blaming* in relation to a more realistic appraisal of responsibility. However, this process can clearly be seen as a struggle for her. She demonstrates this struggle through her resistance to changing her views to a more realistic

appraisal by the way her therapist had to work hard and lead her to the realisation. We sense here how Liz had found it hard to let go of her self-blame at the level of her beliefs which had been so reinforced by others. She and her therapist both struggled to challenge and re-evaluate these engrained beliefs. However, Liz clearly highlights how the important changes in her sense of responsibility did eventually emerge and it was through the intersubjective dialogue with her therapist that this took place.

#### **4.1.3.3 Sub-theme: *Newfound self-worth.***

The changes that were taking place for the participants represented new meaning about their own sense of self-worth and self-acceptance. These new meanings developed from the participants' exploration of their own lived experiences and not based on imposed conventions from the past or misplaced blame. A key route to this more authentic sense of self was through changes in the participants' *appraisals* of self-worth. For many they had lost self-esteem in their traumatic relational experiences and working through the trauma with their therapist encouraged a growing realisation of their self-belief and being worthy within themselves as a human being:

**Linda:** *Which, I, well, it's phenomenal really the difference I feel in myself.*

**Interviewer:** *So you say the treatments helped you feel differently?*

**Linda:** *Yeh.*

**Interviewer:** *How's that, can you...?*

**Linda:** *I think it's, erm, it's made me realise that, erm, I am an important person...*

(228-232)

Linda highlights how the therapy has led to a recognition of her self-worth which she had not experienced before and other participants described similar experiences. Liz notes how she now

feels she is worth listening to, has achieved a lot, and actually recognises that she has a lot to offer others. She states how, 'It reinforced to *me*, in *myself*...' (486). Liz expresses her belief in herself and other participants describe a similar experience. Sally states emphatically in taking ownership of her sense of self, '*That I am actually, well, to quote the advert, what is it? 'Because I'm worth it.'*' (1113-1114).

The participants also provide pointers to how these more authentic self-perceptions developed within the therapeutic relationship. In the extract from Jackie we see again how the presence of the therapist and the therapeutic safe environment allowed an honesty within the relationship which moves Jackie towards this self-honesty for herself:

*'But she's, but she's the first person who sits with you through that and you can talk actually honestly. So you're honest with yourself as well...cos you can, if you like, you can dress it up a bit, and just skim... you know, you can... but you're being honest with yourself as well as with the therapist. And, and but she's allowing you that to... to explore that in a safe environment, the whole time'*

(665-678)

#### **4.1.3.4 Sub-theme: Self in relation to others.**

As the participants discussed their experiences within their therapy they moved beyond consideration of their changes in relation to their inner psychological self-states towards reflecting more widely on the way they relate to others. A key finding within the participant narratives is the significance for some participants of moving to an assertive self, whereas prior to their therapy they describe lacking this ability:

**Tom:** *Erm... it was, it was sort of like I wasn't kind of carrying round a big weight anymore.*

**Interviewer:** *Okay.*

**Tom:** *You know, it's like I could, erm, I could take decisions and do things without dramatically thinking about 'Oh my God, what's the other person going to think about it'...*

**Interviewer:** *Yes.*

**Tom:** *... erm, that was, that was a lot easier.*

**Interviewer:** *Mmm.*

**Tom:** *Erm, although erm, er, it doesn't seem to work with family [laughing].*

(349-358)

In this extract we see Tom developing a more assertive self with others around making decisions although still struggling to assert himself with family. The recognition of his own needs in relation to those of others clearly represented an important area of change for him and other participants also recognised this shift in how they related:

*'I've changed for the better, because I got the feeling that people taking me for granted, the fact that I'd go and see them, I'd always be the one contacting them, not any more no. At the end of the day it's 50/50.'*

(324-327)

These expressions of self-assertion represent an important change for participants in the way they relate differently to others with a more honest expression of their own needs:

*'I mean before I'd, erm, I'd feel bad, if somebody asked me out I'd feel bad saying no, and I felt like I should go because they've asked me. And now I'm like, 'Mmm no', I don't wanna do it so I'm not gonna do it.'*

(347-349)

The route to this more authentic recognition of needs is described by Linda as again a cognitive change, *'I think just sort of switching the way I think about things and putting me first... has made me more confident to be able to say... 'No!'* (196-201). Tom links his changes directly to his therapy but believes that it was a combination of his EMDR therapy with other forms of therapy he has experienced in the past that provided the setting for his assertion, as he states: *'in conjunction with the, er, CBT stuff, I did, I did find myself becoming more assertive.'* (325-326).

#### **4.1.3.5 Sub-theme: Self-acceptance.**

A key change that participants experienced across these differing domains of selfhood was the sense of building this more authentic self. Their accounts show the role of the therapeutic relationship as important to their explorations of their newly forming authentic self. Participants described this authenticity as developing through their therapy in other ways such as through the recognition of realistic vulnerabilities and a clearer understanding of self:

*'... and you know, I have got weaknesses, and erm, there's no weakness in accepting I've got weaknesses. And I suppose, sort of, you know, the treatment has helped me understand me better.'*

(224-226)

In Linda's extract we see her move to self-understanding and the suggestion of her self-acceptance within her narrative. Jackie also demonstrates a level of self-acceptance in learning about her emotions from a therapist who is not *'gushy'*(528) but provides the therapeutic setting for emotional expression:

*'And you're learning to lower your guard, you're learning that it's okay and it's okay to sort of be happy about yourself...'*

(538-539)

In moving towards this emotional self-acceptance and this reconstructed more authentic self the participants' experiences point to an important role for the therapeutic relationship and the self of the therapist in aiding these changes. Linda describes this eloquently in her realisation when it '*clicked*' that she no longer has to live as herself in relation to the conventions and invectives of her mother but can move on now as her own adult, '*an adult in my own right*' (526-531).

#### **4.1.4 Superordinate theme: Journeying beyond trauma to the future.**

As the participants engaged in their EMDR therapy they described how they experienced a change in their life priorities and what mattered to them personally. These changes in life priorities were often described in their narrative accounts in relation to a metaphorical process of movement through their experiences. In addition to the symbolism of movement in their accounts, the participants also describe temporal change across their experiences with a progressive movement from their past lives, which were often associated with fear and distress associated with their traumas, to the present, and then crucially for the participants to a more positive and hopeful future which has meaning and significance for them.

##### **4.1.4.1 *Hidden behind locked doors***

The participants' experiences before they began their EMDR and during the period after their trauma often represented little movement or progression. Indeed the participants' lives were often dominated by their fears and insecurities about being out in the world. Many participants found safety behind locked doors at home:

**Linda:** *Erm, and I didn't feel, didn't feel safe until I was home.*

**Interviewer:** *Yeh.*

**Linda:** *Door locked, curtains closed.*



(118-120)

Linda highlights how the only safety she could experience was when she was behind the locked door of her home. With the doors locked and the curtains closed this sense of being hidden away was palpable in her account. This hiding away was evident in many of the other participants' accounts and was powerfully demonstrated through a recurring image of a locked door and being safe behind the door, but constantly anxious too, as Liz describes:

*I locked myself away, erm, didn't do anything, didn't see anybody.*

(13)

*The house was my refuge...You know, only somebody I let in could come through that door.*

(68-70)

We see here Liz's sense of maintaining some control through the ability to choose whom to let through the door into her home. For Liz, her home was her refuge but it can be suggested that in relation to living her life it had also become a self-imposed prison for her, as she states, '*I just locked everybody out*' (130).

The metaphor of being *locked in* and *locking out* emerged from her actual traumatic experiences of being locked in the house by an ex-partner. Another participant Sally similarly sought physical sanctuary behind a locked door for her physical protection:

*So I went running up [road name] to get home and I, he caught up with me anyway, put the key in the door and I waited till he staggered backwards into the other wall, shot in, slammed the door in his face, and locked the door from the inside so he couldn't get in, rang me parents, they came and picked me up.*

(296-300)

It is clear that for many participants, being behind that locked door within the home offered a sense of safety but as Liz's description attests, could also be imprisoning too. These experiences represented severe restrictions to the lives of many of the participants. Jackie describes how this situation before her therapy was one where, '*You exist, which is not the same as living*' (187). Other

participants, such as Susan, state how they had become ‘*secluded*’ (538). She further provides the emotional sense of what this experience felt like for her within the home:

**Susan:** *Yeh. I’d go home and like I said I’d always lock the door, I’d be checking the windows...*

**Interviewer:** *Yeh.*

**Susan:** *...anybody be knocking on the door I’d always be like, you know, ‘I’m not opening the door, who’s that?’*

(1352-1356)

The starting point for many of the participants was therefore one of being frightened, afraid, and hidden away. For some participants such as Susan, when they did venture out it was a traumatic experience:

**Susan:** *... and that’s what it was, and I didn’t realise how every time I went out I was constantly looking over my shoulder, constantly thinking someone was following me...*

**Interviewer:** *Yeah.*

**Susan:** *... and they weren’t. It was just my mind playing tricks on me.*

(175-179)

Liz also talked about her fears when venturing outside the house as she talked through the contrast following her therapy:

*I am a lot more erm relaxed when I go out. I’m not constantly on edge, looking behind me... basically on the verge of a panic attack all the time. I feel a lot calmer.*

(146-147)

Any literal movement out into the world for these participants was therefore fraught with danger and fear, and their lives were experienced as far from secure with no future vision and not living a fully engaged life.

#### 4.1.4.2 *Reprioritising the future with family*

As the participants began their EMDR therapy their horizons became noticeably wider within their accounts of the changes they experienced. These changes were experienced as a reprioritising across several areas of their lives. One particular area was in relation to those close to them in their lives. Susan identifies how the relationship with her children is now her priority as she looks forward to a future:

*Well one I'm looking forward to erm enjoying my life and my kids for a change instead of just not looking positive, always thinking the worst, so... I can enjoy my kids as kids now.*

(546-548)

We see here her sense of moving forward to a future and within that future she sees her children as being essential to her newfound experience.

Jackie similarly notes her change in priorities around family. In the following extract she describes her recognition of the vulnerability of life and how she came to realise the importance of family in this vulnerability:

**Jackie:** *I learnt more about having the love of your family, not to just take it for granted.*

**Interviewer:** *Yeh.*

**Jackie:** *Because you learn that it can go away at any time really*

(292-295)

For Jackie, family is crucial and she further indicates the defining element of these relationships for her when she notes how the bond with her own children is central to her, '*I learnt that, how strong a bond with my children that we have*' (233).

This prioritising of her family as important was not the only area for her in her journey beyond her trauma. Her focus also extends to her faith and with her re-acquaintance with the *footprints* of her God (170):

*Yeah. You know, there is a God, you can come out the other side.*

(206)

In this reference, she uses in her narrative the analogy of movement when she describes coming through her adversities and her spirituality has been essential to her in that movement through.

As the participants have so far noted, their children are the priority in their futures and for others it is a combination of their family and their spiritual faith. Liz also demonstrates this change in priorities as a re-acquaintance with her grandchildren:

**Liz:** *The grandkids now look, sort of, know who I am...*

**Interviewer:** *Mmm.*

**Liz:** *... run to me, and it feels good to sort of, have grandchildren again I suppose.*

**Interviewer:** *Yes, I can imagine.*

**Liz:** *Erm...*

**Interviewer:** *So your relationships have altered?*

**Liz:** *They've altered dramatically in that we talk to each other, we spend time.*

**Interviewer:** *Yeh.*

**Liz:** *We know each other.*

**Interviewer:** *Yes.*

**Liz:** *You know, I was a stranger to those grandkids.*

(181-191)

Liz, Susan, and Jackie note their priorities are with the family and children they already have but for others, such as Adele, the priority following her treatment is to actually plan to have children and her own family:

**Adele:** *... I mean I'd, I'd never really thought about it until the last twelve months but realising that yeah I do want to start a family at some stage.*

**Interviewer:** *Mmm.*

**Adele:** *I do want to be erm you know looking at life in the bigger sense that actually it's not just about work work work work, and come home have tea and go to bed work work work work. It's, there are other things I want to look at as well in the next few years so putting together a bit of a plan I guess that, not a five year plan, 'I've got to do this by this age' but erm, thinking about where I want to be in life.*

(253-261)

#### 4.1.4.3 Reprioritising future goals

As the participants considered their future lives during the interviews they also note other priorities that are important to them. In the following extract from Susan we see how she is considering the future in terms of a different and more fulfilling career:

**Susan:** *But before, I'd have just stuck with it.*

**Interviewer:** *Yeh.*

**Susan:** *I don't want to anymore.*

**Interviewer:** *No.*

**Susan:** *I want a job that's a career, not like 'Oh it's a job'.*

**Interviewer:** *Yes.*

**Susan:** *I wanna enjoy where I work and I don't enjoy where I work.*

**Interviewer:** *Yeah.*

**Susan:** *And I have been opening my eyes about that. And they have said there are opportunities to progress through the ladder, well up the ladder even!*

**Interviewer:** *Yeh.*

**Susan:** *And I would like to do that.*

(1186-1197)

Adele has similarly reprioritised her life in this regard, as she states:

*I guess my priorities are that I want a happy life, I want to be content and settled, and work towards some financial security, so erm, my priorities are very different*

(505-508)

From Adele's perspective, this change represents a re-evaluation of her working life with a more balanced perspective on the priorities within work and at home:

*And I think the other thing which I guess was not just in terms of the EMDR but the whole kind of like taking time out, six months out of work and thought well actually, I need more of a work/life balance you know?*

(208-210)

For Liz the ability to now focus on work is also a crucial part of her future direction and particularly in contrast to how she saw her position before the EMDR:

**Liz:** *Erm, now I know, well I know one, some day, I will be back in work.*

**Interviewer:** *Mmm.*

**Liz:** *And I know I can go out there and I can do as good a job as anybody else.*

**Interviewer:** *Mmm.*

**Liz:** [pause] *It's kind of given me my life back.*

**Interviewer:** *Has it?*

**Liz:** *In that it had totally stopped for two years.*

**Interviewer:** *Yeah.*

**Liz:** *And now I'm looking round and seeing stuff, almost for the first time.*

(233-241)

Life had been on hold for Liz and given she had defined herself by her ability to work, this extract shows the importance of this changed priority back to a working life for her. On the journey through her recovery she now is able to look outward towards life again with self-belief and, as she says, with a new awareness of life and life's possibilities.

#### 4.1.4.4 *Letting go of the past to move to a future with compassion and acceptance*

For many participants the experience of therapy involved a reprioritising around their lives as they moved into their future. In any journey new experiences are encountered and through the participants' narratives these new priorities and changes have been demonstrated. However, a journey also involves leaving things behind and in several of the participants' experiences they acknowledge how they have had to let some aspect of their experiences go in order to move forward:

**Susan:** *Oh my future looks brighter.*

**Interviewer:** *Does it?*

**Susan:** *Definitely.*

**Interviewer:** *Yeh?*

**Susan:** *Cos I know that, as I said before, it's not gonna affect me anymore, I'm not gonna let it affect my life.*

(531-536)

Here Susan recognises her future as more positive and brighter whilst also letting go of the hold that her traumatic experiences had on her. The participants highlight what this letting go means for them individually and this often involves a sense of forgiveness for others:

*... and not to let it divide. And erm, I have forgiven my family because it was probably their upbringing that's done that.*

(1110-1111)

Jackie describes how for her, letting go involves being forgiving towards her family who she felt had abandoned her in her time of need. Here we see her reflecting on the reasons this happened and how she is now moving beyond any enmity towards acceptance.

Adele similarly has reached a point of acceptance for her father in relation to his responses following the traumatic events surrounding her mother's death:

**Adele:** *Erm, I suppose I'm a little bit more accepting of him. I suppose the EMDR has just added to my knowledge and insight into how we are as father and daughter and how he, probably didn't have the start he needed to be able then act as a supporting figure for mum.*

**Interviewer:** *Mmm.*

**Adele:** *I suppose the change really is that I suppose I'm less, I'm more forgiving of him than what I was, so... erm... yeh.*

(470-476)

Adele realises how the background of her father had contributed to his own difficulties in coping with the death of Adele's mother and in this realisation she lets go of her prior emotions towards him. She further acknowledges how her EMDR treatment has helped to contribute to this change for her. Sally similarly notes this acceptance towards her mother and defines it for her as a newfound, '*compassion, and understanding, towards her*' (388).

Other participants noted the process of letting go in more metaphorical ways. For example, Susan emphasises how previously she was running away from facing her trauma experiences but now she has turned this from running away to now looking forwards in life:

**Susan:** *But now it's like I just look at it and go 'There's not much point in running, I can't keep running for the rest of my life'. I've just gotta get on with things, look forward.*

**Interviewer:** *Looking forward.*

**Susan:** *Yeah look forward in life, not look back.*

**Interviewer:** *Yes.*

**Susan:** *I know they're there, they've happened, there's nothing I can do about it.*

(1107-1112)

Susan no longer wishes to run away for, as she subsequently says, life now is about looking forwards not backwards:



**Susan:** I've just gotta keep going forwards, don't look back, *never* look back, the minute you start looking back, that's it.

**Interviewer:** *Yeh?*

**Susan:** *That's when your life goes downhill. And that's what I was doing for years.*

(1119-1122)

The participants also acknowledged the need to let go in order to move forward in other ways, particularly with regards to recognising what is truly meaningful to them now:

**Interviewer:** *Yeh. And when you say about perspectives what do you mean by perspectives?*

**Jackie:** *Well whereas before you would, erm, if you want go off on a tangent over a small thing...*

**Interviewer:** *Yeh.*

**Jackie:** *... and you think well does that really matter in the scale of things, well actually if you look at what happened then no it doesn't.*

**Interviewer:** *Yes I've got you.*

**Jackie:** *Does it really matter? Erm, is it really worth a whole load of nonsense? You know when you should just look at what's important.*

**Interviewer:** *Yes.*

**Jackie:** *I, I also learnt that I wanted a very simplified life.*

(257-268)

For Jackie, she has reached a point of realising what is important for her in not worrying about things that, in the *scale of things*, are unimportant.

Other participants also acknowledge this type of letting go in situations that would in the past have led them to be startled and panicked:

**Sally:** *... EMDR therapy has helped me to live a more peaceful life I guess really.*

**Interviewer:** *Yes.*

**Sally:** *To let go of things, to understand that I don't need, you know my brain doesn't need to react in that way because it causes me to react physically and it's, the need to do that has gone you know.*

(985-990)

Sally recognises the role of her EMDR therapy in making this change and in her letting go of things and in this extract we experience with her the contrast from how life used to be living on edge to now finding a peaceful life.

Tom also has reached a point of letting go of the unimportant things in his life:

*Erm, erm, sort of being, not unconcerned, but less concerned about the outcome of kind of small things that I'd been worrying about way too much. Erm, to the extent that the small stupid things get in the way of the really important stuff which tends to get pushed to the back...*

(511-517)

*And after a certain point of time certain things can just be kicked out, 'Don't need that anymore'.*

(949-950)

As the participants moved forward with their lives the significance they give to letting go of past experiences, past priorities, and moving towards the things that matter to them was therefore very important as Adele succinctly states in her recognition of the change, '*don't sweat the small stuff*' (551-552).

#### 4.1.4.5 A journey through therapy

A central theme to emerge in their changes is to relate the therapy and the work with their therapist as a journey through which they have travelled from their past selves and experiences to a future. Sally and her therapist explicitly used the analogy of a journey in their work together:

*...so to be able to go somewhere and feel comfortable with someone who takes you down this journey of learning more about myself and how the mind works and how my mind has obviously been working or not working, and how to just enable me to cope better now and in the future*

(881-885)

For Sally this is a journey of learning where she can now cope better with life. She acknowledges both her changed awareness regarding the cause of her trauma and the importance to her of her therapist providing a sense of comfort which, as the earlier analysis noted, is seen as central to the participants' moves towards change and a positive future.

In Jackie's experience of her therapy she also experienced the therapy as a journeying although in a more metaphorical way:

*... you're in a tunnel but you've got one foot in the present and one foot in the past, it's, it's, literally that, it's being able to have that one foot in the present which is allowing you to dip in from a safety angle.*

(1008-1010)

In her extract Jackie provides the insight into how the therapeutic relationship and the EMDR protocol work in conjunction to provide the safety where she can journey back in time to her trauma experiences to process them but then have the safety to return to the present.

At certain points in their therapy the participants also experienced key moments when things began to change for them, as Jackie again explains in relation to the analogy of movement forward:

*But then you start to turn your corner...And you actually realise that you are turning a corner...Erm and you start to feel a lot better about things...you're a survivor not a victim.*

(804-810)

*...but then you start to realise 'Wow, this stuff's working'*

(953)

On the journey there are points where a corner is turned and the participants experience a progression in their therapy. Linda also makes reference to the corners that may lie ahead for her as she leaves therapy:

**Linda:** *So, but, you know, there's gonna be lots of new experiences that are gonna happen that... you know, I'm gonna look forward to embracing that.*

**Interviewer:** *Yeh. What new experiences do you...?*

**Linda:** *I don't know, erm...*

**Interviewer:** *... do you feel?*

**Linda:** *... I don't know, just, it sounds a bit trite when I say 'Just life'...*

**Interviewer:** *Yeh?*

**Linda:** *... because... you don't know what's round the corner.*

(351-358)

Again we see a realism in Linda's account of the unknown challenges that may lie ahead. However, importantly for her, we see how she has reappraised this through approaching those corners by embracing life as it is experienced in its newness.

Tom also experienced a progressive movement through his therapy where his experience was, '*more of a sort of meandering route...that I took to get there.*' (959). The destination of these routes and journeys were highly significant to the participants:

**Liz:** *You know, 14 weeks has made, that 45 odd years...*

**Interviewer:** *Yes.*

**Liz:** *... nothing has ever helped.*

**Interviewer:** *No.*

**Liz:** *The whole of my life I have felt out of place, erm...*

**Interviewer:** *And now?*

**Liz:** *... I'm right where I'm meant to be.*

(843-849)

In this extract from Liz, we gain a sense of the extent of her journey through life, her trauma, and reaching out beyond to her present life. In her use of a temporal referent to the time scale of her change, she emphatically demonstrates the significance of the therapy to her life and sense of place in life. She goes on to acknowledge the realism of life too as she continues on her journey beyond the therapy:

*Okay, occasionally I might still sort of stumble, nothing's perfect but... it's remembering the techniques I learnt...*

(811-812)

As she leaves therapy on this continuing journey she notes how she may stumble at times as she faces life's challenges. She demonstrates not only a realistic vulnerability which is consistent with experiences of PTG but also the way through this where the therapy has provided the ability for her to cope.

The journey for Liz therefore continues beyond the therapy and this is feature of other participants. Sally describes her conversations with her therapist as she approached the end of her therapy:

*... my journey doesn't end, he said you know you will continue to integrate some of what you've learned and if you can carry it forward and you know try and go and do some of these things on your own and test yourself, and yeh it was that positive encouragement and knowing that the journey isn't over. (896-899)*

Here we see how Sally relates her changes to the encouragement from her therapist to continue to engage in life. The therapist's role within the therapeutic relationship therefore provides both a sense of encouragement along with the technical tools to learn to cope in moving into the future. However, Sally also describes another vital element to her experience of change,

*But there's also my level of commitment* (1006)

*And that was a commitment I made to me...* (1036)

In these two extracts we see Sally recognising her own agency for change in addition to the importance she has given to the therapeutic relationship and the technical elements of her EMDR therapy. Susan also indicates the importance of the therapeutic relationship with her therapist in her change:

*But, it was the fact that he, sort of like guided me in the right direction, even though I had the answer, he was sort of like just giving me little pointers and it'd be like 'Oh yeah!'*

(988-990)

For Susan the therapist had been her guide encouraging her to uncover her own agency for change in their therapeutic collaboration. As Adele similarly notes at the very end of her therapy, the focus on the future and the '*sense of achievement*' in her progress was closely linked to the relationship her therapist which was an '*empowering*' experience for her (934 & 940).

The participants had therefore been on many significant journeys through and beyond their traumas and been accompanied on these journeys by their therapists. Within these therapeutic relationships the participants had ventured from behind locked doors to a future with hope and newfound confidence in their selves and for their priorities in life. The participants had recognised that, '*At the end of the day you only get one life...might as well live it, enjoy it*' (Susan: 542). As Jackie notes, I just knew that I was, '*treading in the right direction*' (1069). In the final extract from Linda where she discusses the relationship with her therapist we see the central importance of her therapist in the changes she made to moved on with her life:

**Linda:** *But... I don't know... I don't know... I feel as if she was the key keeper.*

**Interviewer:** *Key keeper?*

**Linda:** *Yeh.*

**Interviewer:** *Yes.*

**Linda:** *Erm, and it made me... [sighs] ... it, it, yeah, it just felt that, that, erm, I was the lock and she was the key keeper. And she gave me, she's given me the key.*

(789-794)

In this final extract we see the enormity of the role of the therapeutic relationship in facilitating change. With this participant's lived experience of her therapist in the therapeutic relationship we are witness to this profound transfer of autonomy to the participant where she now takes ownership of the key to her own importance in life and to unlock her future.

## **Chapter 5: Discussion**

### **5.1. Discussion**

The research study aimed to consider the lived experiences of PTG by participants during their EMDR treatment and the role of the therapeutic relationship in facilitating their PTG.

The Interpretative Phenomenological Analysis approach provided narrative accounts of the participants' experiences from which a range of sub-themes emerged during the analysis. These sub-themes were then clustered to examine superordinate themes which encompassed the lived experiences across all the participants involved in the study. Four superordinate themes emerged from this abstraction process including: *safe and secure, taking back control, a reconstructed self, and journeying through trauma to the future.*

This chapter summarises and explores the participants' themes and superordinate themes, placing them in relation to the literature review and the theoretical and applied knowledge concerning the facilitating of PTG. The clinical applications of the study will then be considered along with strengths, challenges, limitations, and recommendations for areas of further investigation raised by the study.

#### **5.1.1 Summary and assessment of findings**

##### ***Safe and secure***

The participants described the traumatic events they had experienced and the trauma symptoms which they worked on during their EMDR therapy. In coping with these post-trauma experiences they often described lacking safety within their lives with many participants only finding this through the security of being within their home environment. The participants experienced many difficulties in coping with the emotional impact of their particular traumas. As



the participants began their therapy they continued to have anxieties and fears but their accounts reflected additional concerns with the uncertainty and lack of understanding about the process of the therapy and how they would relate to their therapist during this process. Within the first superordinate theme of *safe and secure*, the participants provided insight into these uncertainties at the start of their EMDR therapy but also how these anxieties were allayed during the initial stages of their therapy. The participants described how the therapists' explanations and psychoeducation regarding the process of therapy assisted in ameliorating their lack of understanding and uncertainty. The therapists' explanations about the reactions to trauma normalised their experiences and explanations about EMDR and the process of recovery assisted in removing the uncertainties about the process of therapy. Fisher (1999) has emphasised the importance of safety and stabilisation within trauma treatment as clients begin the therapeutic task of engaging with their distressing memories and experiences. Pheonix (2007) has highlighted how psychoeducation is crucial to the work with trauma survivors to develop safety and self-care through the normalisation of the experiences and reactions associated with trauma. Within the participant accounts it can be seen how the therapists provided this normalisation and safety which was important to the participants' confidence in opening up to their trauma experiences in a safe and secure therapeutic environment.

The participants also experienced a growing sense of safety through their deepening relationships with their therapists which was epitomised by their sense of being comfortable and at ease with the person of the therapist. Herman (1992) has described how the sense of safety provided by the emotional sensitivity and responsiveness of the therapist is a crucial step to the person recovering from trauma. The participants in the current study described how their therapists offered this responsiveness and sensitivity to their emotional distress, allowing them to begin to open up to exploring and reprocessing their trauma experiences during the treatment.

In providing this sensitivity and responsiveness, it can be suggested the therapists were demonstrating many of the conditions suggested by Rogers (1957) as central to client change and

personal growth. The participants' accounts highlighted the empathic, genuine, and non-judgmental stance of the therapist which was important to the participants in opening up about their traumatic experiences. In the move towards recovery and positive adaptation, the therapists were modelling a non-judgmental stance which often countered the participants' own negative self-judgments. As noted in the subsequent superordinate theme of the *reconstructed self*, this re-evaluation of themselves occurred through collaborative exploration with their therapist around realistic interpretations of their experiences which resulted to a more authentic sense of self and responsibility.

The development of trust was also significant and meaningful to the participants as they progressed through these early stages of their therapy. For six of the participants' their traumatic experiences focused on interpersonal trauma and had left them lacking trust in others. It was clear in their accounts that the therapeutic relationship provided an important avenue for them to rebuild their trust in others again. It was also noted how the ability of the therapist to not be overwhelmed by the emotions of the participants was important in the participants being able to entrust their own emotional reactions to the person of the therapist. The therapists also demonstrated a level of emotional attunement and responsiveness to the participants' feelings which, when allied to the sense of presence and proximity of the therapist during the therapeutic work, provided a deepening of trust which participants noted as providing further feelings of safety in the therapeutic relationship. Dworkin (2005) has noted the central importance of the therapist's attunement to the client in providing these relational conditions in order to effectively working with blockages to reprocessing. In the participants' accounts, they provide evidence of this attunement within their interactions with their EMDR therapists.

Within the area of research into trauma and adult attachment, Mikulincer and Shaver (2007) have noted how attachment to the therapist may relate to trauma responses following traumatic life events and suggested these attachment patterns could also operate in the development of PTG. The participants' emphasis on the importance of therapist presence, attentiveness, emotional attunement,

and responsiveness within the therapeutic relationship suggests that attachment systems are activated and operative in the experience of change. Through these attachment strategies, the participants experienced a safe and secure relational environment from which to explore, process, and regulate their emotional experiences as they moved towards adaptive functioning and experiences of PTG.

### ***Taking back control***

The traumatic adversities experienced by the participants had often left them with little agency or control over their lives and their emotional and physical reactions. Within the second superordinate theme of *taking back control* the participant accounts demonstrated how they moved beyond this position to regain control and agency in various aspects of their lives.

The participants increasingly found that they were able to acknowledge emotions such as anger which had previously been suppressed for fear of being overwhelmed by the emotion. As they progressed through their EMDR therapy, they increasingly began to learn how to process and regulate these emotions. Joseph, Murphy, and Regel (2012) have highlighted how the experience of PTG involves affective processing where emotion-focused coping is important to the recovery process and is associated with experiences of PTG. As Prati and Pietrantoni (2009) found, active coping strategies to deal with distressing emotions have been demonstrated to impact on positive adaptation following trauma. The emotion regulation noted by the participants suggests that emotion-focused coping was possibly taking place within the treatment through the naming, expressing, and regulation of emotions. The participants described how the dialogue with their therapists was important in providing the validation and processing of these emotions. As Herman (1992, p. 179) has further noted in accounts from trauma survivors, it is the '*therapist's validating role*' which is central to the client working through the emotional reactions to their aversive life events.

Participants also developed their sense of control in relation to a reconnection with life. This involved a growing confidence in their own autonomy to physically go out on their own without

having to resort to other people to support them. Others found that they began to re-engage with their families again or they began to set goals they wished to achieve in work or in relationships. Hobfoll et al. (2007) have emphasised how growth is operationalised beyond meaningful changes at a cognitive level through an *action* towards life. In the participants' accounts we find this *growth-in-action* taking place. In describing this reconnection with life, the participants emphasise how the therapy has provided the tools to cope with life and in combination with the *gentle encouragement* of their therapists provided the possibility for this reconnection with life.

The participants also demonstrated this taking back control in other ways such as through their agency to make choices in their lives. Tedeschi and Calhoun (1996) have shown how people who experience PTG do so across many domains of functioning and there is a reprioritising of what is meaningful to them across these domains. These changes reflect a sense of agency with participants making new choices in how to live their lives and in prioritising what is important to them. The question this finding raises is how this change takes place and within the participant accounts they provide pointers towards this. The participant narratives highlighted how the therapists' *responsiveness* in the therapeutic relationship provided a route for the growing sense of ownership. The therapists were instrumental in empowering the participants to make their own choices in the pacing and depth of the therapeutic work. This empowerment of agency and control within the therapeutic process itself suggests that the therapist was instrumental in facilitating this growing agency to the participants. This agentic ownership of control was often a new experience for the participants and they recognised how the quality of the relationship with their therapists was central to them regaining this control in their decision-making.

### ***Reconstructing the self***

The experience of traumatic life events had led many participants to feel low in confidence and lacking self-worth. For those who had experienced interpersonal trauma they found themselves experiencing self-blame and feeling worthless about themselves and their lives. Within the

participant analysis it became clear that the process of engaging in their therapy led to major shifts in their self-perceptions and self-evaluation. For a number of participants there was a growing recognition of their *strengths* which had not been acknowledged before their therapy. Tedeschi and Calhoun (1996) have highlighted how the awareness of strengths is an important element of the experiences of PTG and fits with a greater capacity or self-belief to cope with adversity. Within the study by Zoellner, Rabe, Karl, and Maercker (2011), it was suggested that their finding of change in the PTG domains of *personal strength* and *new possibilities* represented a sense of mastery from having proceeded through the therapy process itself. Indeed two participants noted in the present study also acknowledge the potential placebo effect that may be operating for them as a further avenue to their experience of being *stronger*. It may therefore be that this recognition represented their success in addressing their trauma memories and experiences as they went through the EMDR process but also points to an additional role for the participants' own expectations in the process of change. Janoff-Bulman (2004) has suggested that the changes in self-evaluation around newfound strength emerges from the struggle to cope with the traumatic experience. In the participants' further narrative this point is supported as their newly acknowledged strengths were described as directly related to their wider experience with their struggles through adversity.

This change through engagement and mastery during their coping therefore leaves open the question of the extent this change occurs at a cognitive level. From the participant accounts it appears that these changes may have resulted from some combination of mastery over their experiences, reappraisal of beliefs in ability to cope, and the lived feelings which were able to be expressed within the therapeutic relationship. This would again seem to fit with the affective-cognitive processing suggested by Joseph, Murphy, and Regel (2012). The convergence of affective processing of experience alongside the cognitive reappraisal process assisted the participants' changes in self-evaluation. The participant accounts therefore appear to support this convergence of processing factors, giving significance to the cognitive change through the EMDR therapeutic

technique, validation of affective change within the therapeutic relationship, and their own potential expectations of change.

The reconstruction of the self also involved further reappraisal processes in relation to the participants' beliefs around responsibility and blame. For many of the participants, they described experiencing long-standing *self-blame* and feeling responsibility in relation to their traumatic experiences. These self-appraisals had been so ingrained as to impact heavily on their feelings of worth, which they had found difficult to move beyond in the wake of their trauma. However, during the course of the therapy the participants demonstrated how this self-blame became reinterpreted with a much more realistic sense of responsibility around their traumatic experiences and the causal factors involved in the traumatic experiences. Again, this reappraisal of self-belief around blame fits with the model of PTG suggested by both Tedeschi and Calhoun (2004) and Joseph, Murphy, and Regel (2012), where positive self-evaluation at the schematic level occurs as the trauma experiences are processed and accommodated into the person's assumptions about self in relation to experience. The participants again place the therapist at the heart of these changed appraisals. In the intersubjective dialogue between the participants and the therapist, these critical self-beliefs were challenged. The collaborative exploration by the therapist and participant countered the internalised self-blame participants experienced which had often been instigated by the admonishments of their perpetrators and their post-trauma inability to challenging these ingrained beliefs. Within the EMDR protocol, the use of cognitive interweaves and installation of positive cognitions represents a reappraisal process where client re-evaluation of their trauma memories provides a route to challenge blocked processing at a schematic level providing *new adaptive perspectives* (Shapiro, 2001). As Blore (2012) has noted, the importance of these cognitive reappraisals along with resource development and installation aligns with many aspects of the experience of PTG. In the participants' accounts, their therapists appear to provide this cognitive challenge to enable adaptive change around appraisals of blame and a reconstruction of self-evaluation at a schematic level.

These changed self-evaluations were also present in accounts from the participants regarding their wider self-worth. The experiences of many of the participants had been of low confidence in themselves in relation to either coping with the trauma symptoms or in terms of their self-esteem. Further reappraisals were noted by the participants in terms of changes to their reporting of self-worth. They describe how they came to perceive themselves as having *importance* and value both as an individual coping through trauma, but in some cases through reconceptualising themselves as *survivor* rather than as a victim.

The participant accounts also demonstrated a change to a more authentic sense of self which emerged from these dialogues with their therapist. Their accounts show their experiences in relation to others changed from an *external locus of evaluation* (Rogers, 1961) to a way of relating and expressing themselves assertively which was more closely related to their own values and views. Many participants had lived their lives following the trauma in relation to the looming fears of their perpetrators, or in adherence with the conventions and opinions of others. These invectives stood in contrast to their own views and priorities in life which had been set aside after their adversities. During the therapy the participants appear to begin to address these external evaluations and be more proactive in asserting their changed beliefs and opinions. As has been noted earlier in this discussion, the participants take control over their choices but within this theme the change also encompasses an authentic acceptance and positive regard for themselves where they are able to say *yes* or *no* on the basis of their own choices and values. The participant narratives also highlighted how their engagement with their therapist led to their growing sense of their own self-acceptance where they lowered their emotional guard and began to understand their sense of '*me*' better and a sense of being at peace with themselves for the first time.

It could be suggested from a humanistic perspective that these changes around a newfound sense of self represent a developmental process taking place for the participants. The personal valuing and positive self-regard resonates with Rogers (1959) views on self-development as involving the emergence of unconditional self-regard and authenticity. Flanagan, Patterson, Hume,

and Joseph (2015) have highlighted the potential importance of unconditional positive self-regard in experiences of PTG. In relating the participants' accounts of change within a person-centred framework the participants' experiences align with a person-centred conceptualisation of growth as a change to a more authentic self and the operation of the organismic valuing system and self-actualisation (Joseph & Linley, 2005). Within the participants' narrative accounts of their therapeutic relationship with the therapist, the importance of the role of the therapist's presence, empathic understanding, and non-judgmental acceptance was demonstrated during the process of these changes. These qualities of the relationship provided a safe environment where the participants talked honestly about themselves without having to hide or suppress their experiences. It can be tentatively speculated from the participant experiences that the unconditional positive regard the therapeutic environment provided allowed the participants' own development of unconditional positive *self*-regard. It therefore appears that there may be a close relationship between these factors operating within the intersubjective space between therapist and participant which is important to the development of PTG in the domain of personal change.

### ***Journeying beyond trauma to the future***

The participants experienced further changes as they engaged in their EMDR therapy. In the superordinate theme of *journeying beyond trauma to the future* their accounts emphasised a temporal change experienced from their initial experiences post-trauma, to the events within their therapy, and then noted changes reflecting an orientation of their lives towards an improved future.

The experiences of the participants as they entered therapy was one of having often been avoidant of either their emotions, the outside world, or their authentic sense of self. The participants described their changes in a number of metaphorical ways and through several analogies. The first concerned a representation of the participants' experience pre-therapy as being *hidden away* behind a *locked door*. For many, their only real safety seemed to be within the home where they could lock themselves in and lock others out, so ensuring their security but still experiencing the fear of further



potential harm. This *being locked in* was a literal experiences for some participants but it also operated on a more symbolic level in terms of locking themselves in emotionally and locking people out in terms of interpersonal contact. As they engaged in their EMDR therapy the participants described the changes they experienced through an additional metaphor of *movement* from this fearful and anxious state, towards a future which was distinctly different. This future vision was associated closely with a reprioritising around the important things in their life. As Tedeschi and Calhoun (1996) proposed, this reprioritising represents a central feature of experiences of PTG. The participants in this study experienced a reprioritising across different areas of their lives both during their therapy but especially in their aims and priorities for their futures. 'Family' was clearly identified as a main focus for the majority of the participants. They described their deeper relationships with their children or in improvements within their wider families and social relationships. For one participant this changed priority centred on beginning a family of her own with her partner, and for another it was the strengthening of her spiritual belief and seeing the world differently for the first time. This change in life philosophy expressed by the participants supports the conceptualisation of PTG put forward by Tedeschi and Calhoun (2004) where there is a reprioritising of life across different domains of interpersonal and existential functioning.

This reprioritising extended to other areas of life with some participants acknowledging their changed priorities in more practical terms with regards to their goals, such as either a more fulfilling career, getting back to work, or having a much improved work-life balance. Other areas of their pre-trauma lives were given less meaning and significance during this reprioritising and there was a letting go of trivial aspects to their lives which they now felt were insignificant. In these engagements with new priorities, goals, and aspirations in life it can again be seen how the *doing what is meaningful* process suggested by Hobfoll et al. (2007) was operating for the participants in their experiences of PTG. Alternatively, from a more humanistic conceptualisation of these changes this reprioritising could represent moves towards a more fully-functioning person in line with more humanistic conceptualisations of growth (Joseph, 2004; Rogers, 1959).

A sense of *movement* away from their past trauma experiences to a reprioritised future was a clear metaphor that emerged from the interpretation across the participants' narratives. This movement also showed itself through the way participants were *letting go* of the past trauma, accepting a realistic vulnerability of themselves in the world, and of a clear future place which they were moving towards. Within the reprocessing phase of the EMDR this movement analogy was also noted where there was a sense of moving backwards and forwards from the experiences of the past trauma and back to the present. The safety protocol within the EMDR provided this movement analogy where the participants also described the temporal quality of this reprocessing with *one foot* in the past and *one foot* in the present.

As the participants moved away from the past trauma memories in their processing they moved towards a changed future orientation and several participants noticed this in relation to *turning a corner*. However, they also noted in the future path that lay ahead of them that challenges may present themselves. They also recognised a realistic vulnerability to their experiences and the importance of leaving their trauma experiences in the past, accepting that they needed to let go in order to move forward. This acceptance of letting go also extended to a change in their acceptance in others fallibility as well as their own. For some participants a sense of *compassion* for others and of *forgiving* in order to move on was evident. Realistic vulnerability and compassion have been noted as relating to experiences of PTG within Tedeschi and Calhoun's model of PTG (2004). They suggest this acknowledgement of the vulnerability of life is a crucial stage in the experience of recovery and growth following trauma.

In recognising the possibility of a changed future, the participants also noted how they were now more able to cope both practically and emotionally as they moved on with their lives. They described how the therapy provided *tools* for them to use in their coping with these future challenges on the journey ahead. As Prati and Pietrantonio (2009) point out, the ability to cope in terms of problem-focused coping and emotion-focused coping is essential to recovery and the experience of growth. Throughout their journey the participants returned to the experience of safety

and trust which the therapists provided as they accompanied the participants through their therapy and towards a vision of themselves as coping and now beginning to *live life to the full*. Here again the alignment of the participants with a humanistic conceptualisation of change can be noted where the person moves towards being more fully functioning (Rogers, 1959).

In examining the analysis of the participants' lived experiences as they went through this process of change, one participant provided a final enduring metaphor within her narrative account which emphasised the important role of the therapist in assisting in this movement towards positive change. This metaphor placed the therapist as the provider of a key, *the key keeper*, which metaphorically represented the participant's regaining of control to move beyond her trauma. From the interpretation of the participants' narratives, this symbolic image encapsulated the lived experiences of the participants in this study where their therapists played a significant part in enabling them to move through their *locked doors* and beyond their past trauma experiences towards brighter futures.

### **5.1.2 Concluding remarks: The facilitation of posttraumatic growth**

The participant accounts of their experiences within their EMDR therapy and their moves beyond their trauma provided a rich narrative description and important insights into the lived experience of the participants as they engaged in their therapy. Through the application of Interpretative Phenomenological Analysis these insights emerged from the participants' experiences and allowed the research aims to be considered and explored.

The experience of the participants in coping with their trauma prior to entering therapy was of being fearful, avoidant, anxious and hiding away from life. Their relationships with family and wider social relationships were disrupted, and their engagement in the world and their quality of life were highly restricted. At the start of their therapy they were sometimes cautious, anxious, often lacked understanding around the therapeutic process, and with some initial doubts about how the therapy would help them. As they engaged with their therapist these cautious feelings changed.

They experienced the therapeutic relationship as providing safety, trust, and security which was shaped by their therapists' emotional attunement to their experiences involving compassion, empathy, and unconditional positive regard, in conjunction with a professional and knowledgeable approach in the implementation of the EMDR treatment. This therapeutic environment allowed the participants to engage with their trauma at a cognitive and affective level. In processing their traumatic experiences and memories the participants opened themselves emotionally to work through their experiences, setting aside previously held emotional barriers which had operated to ensure their safety in the wake of their distressing life events. As they moved through the therapy they noted changes in their functioning where they took back control of their lives and reconstructed their sense of self as coping and with self-worth. Their priorities in life changed and they began focusing on a future life with family and new priorities.

In providing insight into their therapeutic engagement, the participants' accounts related closely to many of the previous research findings into the experience of PTG. However, this study aimed to extend this knowledge in considering the extent to which these experiences were facilitated through the therapeutic relationship. Calhoun and Tedeschi (2013) have described a facilitative model of PTG where the therapist can aid the emergent experiences of PTG through an expert companion role within the therapeutic relationship. The participant accounts supported this general facilitative role. Their demonstration of the therapist's qualities of understanding, empowering agency for change, knowledgeable insight, and the gentle encouragement and challenge around their self-evaluation and appraisals highlighted this facilitative role. However, it can also be suggested that the participants' accounts move further in identifying the important elements within the therapeutic relationship which aided the emergence of PTG.

The participants emphasised the qualities within the therapeutic relationship with their therapist which appear to have been important to their experiences of PTG. The quality of this relationship was not just based on an expert companion role but provided a therapeutic environment directly relevant to the changes found in experiences of PTG. In the unconditional positive regard,

the empathic attunement, and the therapeutic connection which participants experienced in their therapeutic relationship with their therapists, it is suggested that these relational qualities mirror many of the common factors shown as necessary and sufficient to personal growth and self-actualisation within the person-centred approach (Rogers, 1957). Joseph (2015) has intimated how these conditions provide the therapeutic context in which PTG can emerge for clients as they work through their trauma experiences. However, this study also highlights how client-therapist attachment may also play a significant part in providing the conditions within the therapeutic relationship necessary for the emergence of PTG. Attachment involves a need for proximity, safety, and responsiveness from a significant other (Bowlby, 1988), and the participants highlighted how these needs were present and attended to in the therapeutic relationship and led to the security necessary for emotional and personal explorations associated with PTG.

It appears from the findings that the therapeutic relationship is central to the experience of PTG. However, from the participants' accounts, it could be further suggested that the changed life philosophies, reprioritising and reconstructive processes around the sense of self, fit well with a cognitive understanding of PTG. Cognitive reappraisal allows clients to engage in what Janoff-Bulman (1992) has identified as a process of accommodation of trauma experiences into a new assumptive conceptualisation of self, and self in relation to the world. It has been noted how the elements of treatment which have a cognitive basis within EMDR, such as cognitive and relational interweaves, offer the opportunity for the reprocessing of trauma experiences and memories which are influential to client change (Dworkin, 2005). Additionally, Blore (2012) has noted how the installation of positive resourcing and positive cognitions aligns with experiences of PTG. The participant accounts go some way to supporting the importance of cognitive reappraisal processes within EMDR as important to their experiences of PTG. In the participants' dialogical discussions and therapeutic interactions regarding safety and understanding, agency and pacing, and cognitive processing within the treatment, it can be seen how the EMDR processes assisted participants in their movement towards experiencing PTG.

The findings from the participants' experiences in this study therefore demonstrate how a multiplicity of factors may be influential to the facilitation of PTG. The therapeutic relationship built on trust, safety, unconditional positive regard, responsiveness, and emotional attunement between therapist and participant, provide the relational conditions for participants to explore their emotional experiences and alternative conceptualisations of themselves and their relationship to their post-trauma world. However, for PTG to emerge the participants also emphasised the importance of affective-cognitive processing inherent in the EMDR therapy. Their demonstration of cognitive reappraisal was influential in their reconstructions of self and the emergence of newfound priorities for their futures. In this regard, the findings of this study support a model of PTG which takes account of the qualities of change noted within the functional descriptive model of PTG (Tedeschi & Calhoun, 2004), but also aligns with a model of PTG based on an affective-cognitive process model proposed by Joseph, Murphy, and Regel (2012). As Joseph et al. highlight, this model takes account of the many points in the recovery route following trauma where clinicians can provide the conditions important for PTG to emerge. This can be at a cognitive level or with wider affective exploration and change within the therapeutic relationship. The findings from this study therefore offer insight into the crucial role the therapeutic relationship plays in facilitating PTG. It also acknowledges how the therapeutic relationship provides the therapeutic context for effective cognitive reprocessing within EMDR therapy.

The integration of these areas of clinical practice provide the opportunity for clients to explore their experiences as individuals journeying beyond their struggles with their trauma to find meaningful futures, with new insights into themselves as survivors, and new priorities for their future lives.

## 5.2. Implications for practice

The exploratory findings from the participant accounts in this research extend knowledge into the role of the therapeutic relationship in the facilitation of PTG during EMDR therapy. The majority of existing research into the experience of PTG during therapy has focused on the cognitive elements believed important to experiences of PTG. The participants in this study clearly engaged at a cognitive level through their reappraisals around their self-concepts and the meanings associated with their trauma experiences. This study therefore supports the proposition that extant therapies for PTSD with cognitive and information processing elements, such as EMDR or TF-CBT, may be important to the facilitation of PTG. This suggestion fits with current theoretical suggestions of the role of positive accommodation of trauma related information into revised schematic changes around self, and self in relation to the world. However, the findings of this study move beyond the relevance of cognitive processing in the facilitation of PTG.

The participants' accounts demonstrated how the quality of the therapeutic relationship they had with their EMDR therapist was of central importance to their experience of change and PTG. The therapeutic relationship provided therapeutic conditions for the development of safety, trust, and agency, and the subsequent emotional and cognitive processing. The relationship with their therapist allowed them to explore and re-evaluate their lived experiences, their sense of self, and self in relation to their future world, in order to alleviate their symptoms but also experience PTG.

These findings have important relevance to clinical practice where the provision of certain therapeutic conditions could provide clients with greater opportunity for them to explore their experiences of positive adaptation following their trauma. The experiences of the participants in this research highlight how the provision of the person-centred conditions of empathy, unconditional positive regard, and relational depth were important to their ability to explore wider changes in their functioning within their therapy beyond symptom reduction alone. An important finding from the interpretative level of analysis of the participant accounts was the significance of attachment factors

within the therapeutic relationship. The therapists' emotional attunement, presence, and proximity provided during the therapy was experienced by the participants as an important relational context for safe exploration of emotions and experiences of self through the EMDR reprocessing phases. The experiences of the participants in this study highlight how these elements of the therapeutic relationship had a significant role to play in their recovery from trauma when allied to the existing treatment protocols. It is therefore recommended that practitioners pay particular attention to the relational elements of their practice, where a focus on the therapist qualities of empathy and unconditional positive regard, when allied to an attentive and responsive therapeutic environment, allow the necessary safety and emotional engagement shown by this study to be central to experiences of recovery and PTG.

The participant accounts demonstrate the central importance of the development of trust and safety within the therapeutic relationship. Most trauma therapies acknowledge the role of the therapeutic relationship for effective recovery but this acknowledgement is often seen as secondary to the application of protocol-driven technical elements of the treatment (Joseph & Murphy, 2013). The present research findings suggest that within the clinical setting greater awareness and fostering of these relational elements in existing evidence-based trauma treatments would aid not only effective recovery but would provide the opportunities for clients to explore their experiences of authentic self, their assumptive worlds, and their priorities for their future lives.

The participants in the study also highlighted the importance of being *heard* and of naming their positive changes in their dialogue with their therapists. This was shown important for the consolidation of their improved self-evaluations, emotion regulation, and re-engagement with life expressed within their therapeutic relationship. These findings are supportive of Calhoun and Tedeschi's (2013) model of PTG facilitation but importantly lead to a recommendation that practitioners be aware of, and listen closely for, the possibility of PTG inherent in client narratives of adaptive change. When the client brings these narratives to the therapy setting, the recommendation from this study is for therapists to reflectively label and explore these changes



with the clients in order to accommodate these changes at a schema and affective level. However, as Calhoun and Tedeschi have emphasised, this must always be done sensitively and guided by the client's experience rather than by expectations of change.

A further clinical proposition supported through the research findings concerns the conjunction of the therapeutic relationship and the technical elements of the EMDR treatment protocol. The study findings suggest therapists develop a much clearer awareness of the importance for the therapeutic relational elements discussed above to be integrated with the technical elements of safety, collaborative engagement, and adaptive information processing within existing treatment protocols, in order to assist in the facilitation of PTG. This acknowledgement of common and specific factors within trauma treatments has been suggested as central to recovery from trauma in the clinical setting (Meichenbaum, 2013). It would provide individuals with greater opportunity to change in positive ways beyond alleviation of symptoms and towards the rebuilding of a more adaptive and assumptive belief system synonymous with PTG.

The findings of therapeutic technique and common factors in the therapeutic relationship working in collaboration also suggests a renewed consideration in the commissioning of services beyond a narrow focus on symptom reduction alone. The *revolving door syndrome* has long been recognised as a difficulty within the medical model of mental health provision. However, as this research suggests, commissioning of treatments such as EMDR, which incorporates both technical protocol-based processes and has a strong person-centred focus, offers effective treatment for both PTSD recovery but also assists clients to be more fully functioning so aiding relapse prevention.

The study's findings also have implication in the training of practitioners within existing trauma treatments. The findings of this research suggest that within the training of Counselling Psychologists and those practitioners working with trauma, awareness of the possibility for PTG to emerge as they implement their treatments could offer further benefits to their clients for acknowledging and facilitating the possibility for PTG. It would also be important within the training environment to highlight the central importance of the therapeutic relationship, not just as

the safe platform to implement trauma therapy protocols, but also in providing the relational conditions for the possible emergence of PTG and a more fulfilling and improved quality of life as they leave therapy.

The findings of this research therefore suggest an integrative perspective involving the important elements noted within the therapeutic relationship, allied to the technical elements of trauma treatment within EMDR therapy. In highlighting this integration of therapeutic relationship and specific treatment factors, the research does not suggest support for what Joseph and Linley (2008b, p. 342) describe as a potential paradigm shift to, “*supersede and replace existing ways of thinking about, and working with people following trauma.*” However, it does provide support to a more integrative perspective in trauma intervention, bridging the gap between the importance of common factors in the therapeutic relationship and specific trauma interventions in assisting clients to move towards both recovery and more adaptive functioning.

It has been noted earlier in this doctoral thesis how the Counselling Psychologist’s role is predicated on the importance of the therapeutic relationship as a driver for change. The role of a qualified Counselling Psychologist also rests on the integration of many modalities of practice and competencies to meet the varied psychological and emotional needs of clients (Health and Care Professions Council, 2012). The findings of this research reiterate the importance of the therapeutic relationship to the Counselling Psychologist’s work with trauma clients. However, the findings of this study also emphasise the integration of therapeutic relational factors with the specific trauma interventions in EMDR therapy. These findings further demonstrate the key role that EMDR can play in the remit of Counselling Psychology practice, offering the potential to provide increasingly effective interventions for trauma to facilitate not only client recovery but experiences of posttraumatic growth following traumatic life adversities.

### 5.3. Strengths, challenges, and limitations

The research study explored the lived experiences of the participants through the use of Interpretative Phenomenological Analysis. This qualitative methodology has been suggested by Smith et al. (2009) as suitable to the production of individualised analysis located in the unique narrative accounts of the participants. In this present study the IPA approach provided the necessary qualitative exploration of the participants' experiences in order to produce what Smith (2011) has termed the balance between convergence and divergence of participant experiences. In maintaining this balance, one of the study's strengths was the ability to explore the experiential claims of each individual participant within the production of the wider encompassing superordinate themes.

The IPA methodological approach could be argued to have provided some limitations in the exploration of the role of the therapeutic relationship in experiences of PTG. Willig (2013) has highlighted the influence a researcher has on the research endeavour and the findings of a study. Any interpretations of the participants' experiences emerge through the interpretative analysis of the researcher who brings their own assumptions and presuppositions to the research process. However, in recognising the potential for this influence, I aligned my research practice with the recommended qualitative conventions and processes of reflexivity, bracketing and engagement in the hermeneutic circle (Smith et al., 2009; Yardley, 2008). Through reflexive engagement at each stage of the research process, a counter to any potential bias was acknowledged ensuring a level of trustworthiness to the findings which was rooted in the participants' own narratives and confirmed through the textual quotes and thematic audit processes.

The methodological approach also presented some challenges as the analysis progressed. Five superordinate themes were abstracted in the early analysis but one main theme was subsequently merged within another superordinate theme. This theme was *hidden and locked in* where the participants' pre-therapy experiences had been of being hidden away and avoidant of engagement in life. Many of the participants could only find their sense of safety within their homes

behind locked doors. However, as the analysis progressed the superordinate theme of *journeying beyond trauma to the future* emerged as an increasingly important theme for the participants in their accounts which appeared to encompass the *hidden and locked in* theme. I turned for assistance in how to approach this overlap to the discussion by Smith (2011) on the quality of IPA research. Consideration was given to Smith's focus on the balance of convergence and divergence in analysis to address this dilemma. Taking this balance and my alignment to the abstraction guidelines of Smith et al. (2009) I realised that a convergence of these themes would provide validity through the thematic representation of the participants' experiences as movement from the effects of their past trauma to a different positive future. The superordinate theme of *journeying beyond trauma to the future* therefore gave voice to the participants' experiences as the analysis moved through the hermeneutic circle.

The purposive sampling method used with the study represented a limitation to the study. Smith et al. (2009) have suggested the use of a homogeneous sample to explore in depth the particular phenomenon or psychological concept under investigation. The research therefore recruited participants who had experienced trauma, received a clinical diagnosis of PTSD, and who had received EMDR therapy for their difficulties. However, in the sampling process the participants were not selected by specific trauma type and of the seven participants recruited to the study six had experienced interpersonal trauma of a sexual or physical and emotional abusive nature, with one having experienced traumatic bereavement. It could therefore be suggested that the participant sample was very narrowly constrained to one particular trauma event. Given the findings focused on the central importance of the relational qualities inherent in the participants' accounts it could be considered that the interpersonal nature of the majority of the participants' trauma would resonate more strongly with the relational aspects within the therapeutic process in comparison to other trauma populations. However, this narrowly constrained sample could conversely represent a strength of the study, providing the ability to explore in depth the fit between the particular therapeutic conditions inherent in the therapeutic relationship, relationally based trauma

experiences, and PTG. This proposed counter argument to this particular limitation would also seem to fit with some suggestions within the research evidence of particular domains of PTG being associated with different elements of the therapeutic process (Zoellner, Rabe, Karl, & Maercker, 2011). It should be stated that this remains a conjecture at this exploratory stage of investigation but would suggest important areas for further research in differentiating out the active elements of treatment in relation to PTG.

Another limitation within the sampling strategy concerned the gendered ratio within the sample with only one participant being male. Within the research into PTG it has been found that females experience more PTG than males but the effect size of this gendered difference has been shown to be small to moderate (Vishnevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010). Within the current study the preponderance of females in the sample could have influenced the broader understanding of the role of the therapeutic relationship and experiences of PTG. It could be that the females in the study experienced the therapeutic relationship as more meaningful to their positive changes. However, returning to the evidence from the male in this study, his experiences were in accord with those of the female participants during the analysis and so this potential limitation may be less influential to this study but it is suggested that future studies aim to examine the facilitation of PTG within a wider gendered population to further clarify and differentiate effects.

The current study also made use of self-report narratives of participants' experiences which could have led to biased accounts where retrospective recall of experiences is influenced by other proximal factors occurring in the participants' lives (Frazier & Kaler, 2006). The research made efforts to counter this possibility through recruiting participants within a year of completing their treatment. In gaining participant accounts close to their discharge from psychological therapy services, it could be suggested that the experience of their therapy would therefore be relatively vivid to the participants. However, the findings of this study must still give regard to the retrospective quality of the participants' accounts in the light of this methodological limitation.

#### **5.4. Recommendations for further research**

Despite the noted limitations of the present research, the richness of the participant accounts provided further knowledge and awareness around the processes involved in the facilitation of PTG within EMDR treatment. As an exploratory investigation into the role of the therapeutic relationship, the research has provided pointers for further research which could build on these initial exploratory findings. The methodological limitations of retrospective self-report suggest that further research which takes a longitudinal perspective employing a mixed-methods approach could provide more differentiation to the insights highlighted in this study. This further methodological approach would help understand the temporal nature of change within a concurrent treatment programme where qualitative and quantitative accounts, and measures taken throughout the duration of therapy, would highlight more specifically the processes and key experiences that occur for clients. The findings from this research methodology would provide greater generalisability to these subsequent findings.

The exploratory focus of the study highlighted the importance of the therapeutic relationship in facilitating PTG in a clinical setting. In order to extend the findings, it is suggested that further research examines more closely the specific elements of the therapeutic relationship which have been shown as important to the participants of this study, and also in relation to wider populations who have experienced different trauma experiences. The findings regarding attachment patterns experienced by participants in this study would represent one key area for further investigation. Existing psychotraumatology research which has focused on PTSD and attachment has noted how therapist-client attachment styles have clinical implications for individuals recovering from complex trauma (Pearlman & Courtois, 2005). The findings of this current research also suggest that further investigations would be beneficial into attachment, and the match between client-therapist attachment styles and experiences of PTG. This research would build on current findings

and provide further understanding of the role of attachment within the therapeutic relationship and how its influence to the facilitation of PTG.

In addition to a focus on the elements of the therapeutic relationship that have been suggested by participants as important to PTG, the findings also highlighted the central position of cognitive changes which took place for the participants in relation to their self-appraisals and the meaning making processes involved in their change. It could be suggested from these findings that a further research focus on the cognitive processes involved in this reconstruction of self and assumptive worldviews would also add valuable understanding to the growing body of knowledge at a clinical level within current therapies such as EMDR and TF-CBT.

These further avenues of research would assist in more specific understanding into the role of the therapeutic relationship and cognitive processing in experiences of PTG. In carrying out this wider research employing a longitudinal mixed-methods approach, the findings would also provide greater generalisability. This additional research could then assist in the refinement and effectiveness of current clinical models of trauma recovery and PTG.

## **Chapter 6: Reflective Appraisal of Research**

The research process involved in this doctoral thesis represented a sequence of stages through which the research moved from inception and planning, implementation of the IPA, and the subsequent representation of the participant experiences during analysis. Within these various stages I found that my development as a researcher and as a scientist-practitioner was being informed by the many experiences, tensions, set-backs and accomplishments that I came across as I carried out the doctoral research. In this reflective appraisal, an account of the insights gained along the way will be given and an indication of how these have contributed to me as both a developing researcher but also as a trainee moving towards qualification.

The research project provided many different challenges to me as I developed, planned, and implemented the study. Throughout the course of the research I maintained a reflective journal which started out as a list of supervisory dates at the very beginning but soon became essential to my research project at a deeper level. At the outset of the research I was aware of how the decisions I made to produce research in the area of trauma, and particularly posttraumatic growth, was shaped by many different experiences. My starting point on the journey towards this research topic began before my doctoral studies during my undergraduate psychology experience. During my undergraduate studies I became interested in the newly-emerging concept of stress-related growth. The concept has similarities with posttraumatic growth but focuses more on the everyday stressors which can lead to personal change (Park, Cohen, & Murch, 1996). In my clinical work prior to entering the doctorate course I developed a much more in-depth knowledge into trauma and trauma treatments. As I engaged in the doctorate training this knowledge became more refined as I developed my academic and practitioner abilities. In an assignment on trauma and recovery in relation to life-span development my understanding progressed but it was with my engagement with my client work on placement that I also began to recognise the diversity of life events and



relationships which resulted in varying experiences of trauma for clients. The inception of the research into posttraumatic growth was therefore developed from a convergence of many of these differing strands of prior experience; from my academic starting point at the undergraduate level, through to my developing clinical experiences on a variety of placements.

The early entries I made in my research journal as I started out on the research allowed me to acknowledge the many decisions and events that were involved in the research in order to get the project planned and organised. In making these decisions I acknowledged how I wanted the research to be meaningful in providing relevant clinical knowledge which would have application to the role of the Counselling Psychologist and to the therapeutic community working with trauma. In recognising these motives, I felt my progress within the trainee Counselling Psychologist role was also beginning to ground me within the ethos of the scientist-practitioner as I set out on the start of the research project.

A central concern as the research gained pace, and which was a fundamental learning point for me as a developing researcher, concerned the methodological direction of the research and my ability as a researcher to cope with the demands and realities of real-world research carried out with a clinical population within an NHS clinical setting. I had set out originally to carry out a mixed-methods study with an initial quantitative phase examining the pre- and post-therapy changes in PTG by way of psychometric measures. I would then follow this with a qualitative study to explore the role of the therapeutic relationship in facilitating growth within the experiences of participants as they moved through their EMDR therapy. The research was approved by both the University of Wolverhampton and the Black Country NHS Research Ethics Committee and I engaged with the three psychological therapy services involved in the study to begin the research. However, it became apparent as I moved through the first months of the research that there were insufficient participant numbers coming forward to carry out the quantitative phase of the research. My supervisory discussions were crucial to me at this time in considering my options and responses. In

our discussions it was decided that it may be beneficial to recruit a further psychological therapy service to the study. I turned my attention to this and was successful in obtaining agreement for another psychological therapy service in Liverpool to be involved only to be thwarted in gaining their support with this. Unfortunately, the new service was informed within a month of my engagement with them that their service contract was not being renewed following a tendering process and the service would no longer exist to assist in the research project.

This was a difficult time for me but I remained focused in looking at other avenues to progress the research. Following discussions with the existing service managers, and lead clinicians already involved in the research, I considered further what the difficulties were in recruitment on the ground and how this could be rectified. In these discussions it became apparent that the administration of the quantitative research measures were difficult for the therapists in their increasingly time-stretched services. Potential participants were described as being more willing to take part in just the interview phase of the study than both the quantitative and qualitative phases. After considering this in supervision, it appeared clear to me that there would be a greater uptake in participant numbers if the research moved to a purely qualitative study. Following supervision, I therefore decided that I would apply for an amendment to the research in order to focus solely on the qualitative study to assist in recruitment. This application was successful and approval was granted by the Black Country NHS Research Ethics Committee whilst retaining the original qualitative protocol as originally planned (See Appendix 19).

In dealing with this research dilemma I learned much about the research process and the difficulties associated with carrying out research within psychological therapy services. It was through my monitoring of the research that I was able to recognise the difficulties with recruitment early enough to make amendments and, having set up really good lines of communication and liaison with the services on the ground, I was able to implement these amendments. In my reflective notes I recognised the uncertainty these events had created. However, they also emphasised how

adaptable and versatile I had been in responding to the needs of the research, the services, and ultimately the participants, whilst also recognising my perseverance in facing these research adversities and setbacks.

As the qualitative research got underway, my attention turned to the process of engaging with the participants and their research interviews. In the interviews, the participants talked through their traumatic experiences and their experiences of their EMDR therapy. I noted in my journal how I had recognised within my initial interviews that a few of my responses within the participant dialogue were made more from my *therapeutic presence* rather than from a researcher interviewer stance. On some occasions I would be encouraging around certain statements rather than having a broader exploratory curiosity. However, I was increasingly able to use my self-awareness and immediacy in the moment to bracket off these responses and my therapeutic style. In this way, I was able to prevent deflection away from the participants' own accounts and continued to develop and maintain the rapport necessary for them to openly explore their experiences. This was an important learning point for me in carrying out research interviews in comparison to a therapeutic dialogue and in my reflections I noted my recourse to Kvale and Brinkmann (2009) to consider this interview experience. I realised how I was beginning to develop what Kvale and Brinkmann term the *interviewer qualifications*. It was through my reflexive practice that I was demonstrating the necessary ethical and scientific responsibility and flexibility to get to the "existential importance of the interview topic" (Kvale & Brinkman, 2009, p. 168).

During the data analysis stage of the IPA methodology, I became increasingly aware of my responsibility in representing the participant voices. The abstraction of themes sometimes felt like a move away from a *voicing* of the individual participant's experiences. Wagstaff et al. (2014) have described this discomfort with the comparative analysis of abstracting themes across participants which they suggest can seem like a *moving away* from the individuals account. However, as the analysis progressed I came to realise the benefit of this distillation of the meaning units into sub-

and superordinate themes. This change occurred through my acknowledgement of the importance of the hermeneutic circle in being able to return to the individual transcripts to allow communication between the overarching theme and the individual participant accounts. In using the cycling process, the theme and the narrative account then informed each other in a two-way interaction of reinforcing the theme by the account, and the account reflecting the theme. As the superordinate themes took shape I therefore felt that they were increasingly encompassing the voices of all the participants in the hermeneutic circle and provided the depth of meaning and significance to represent the participants' lived experiences.

My research journal entries also brought to my awareness how I was developing an intimate knowledge of each participants' experiences through their accounts. The immersion within the accounts provided a depth of awareness for me of both the therapeutic process they each went through with their EMDR but also their strengths, uncertainties, hopes, fears and aspirations. In many ways this led me to think about my own clinical practice and my therapeutic relationship with the clients I work with. My analysis was highlighting just how important the therapy was for these participants as they worked through their difficulties, and the importance they gave to the relationship with their therapist. I had experienced some level of this insight myself whilst undergoing my own therapy as part of the personal development element of the doctoral course. However, in carrying out the research I gained deeper insight from the participants' perspective into just how significant the therapist's role is, both in providing an effective therapeutic technique in the EMDR to assist them overcome their distress, but also the central importance they give to the person of their therapist in the process. As the research carried out by Knox (2008) has highlighted, the therapeutic relationship can be experienced by clients as a *relational depth* which can be highly meaningful for clients in the key moments during therapy. This deeper recognition of the central position I myself hold as a practitioner within the therapeutic situation therefore emerged through the intimate knowledge of these lived experiences and individual meanings participants provided. In this sense, the research not only provided empirical knowledge about these processes within the

therapeutic relationship but also related directly to my own conceptualisation of myself as a practitioner as I sit with clients within the therapeutic setting.

The research endeavour therefore represented many significant insights for me. The recognition of my ability to adapt reflexively to the adversities of doing research within the real world environment of psychological services was an important learning experience for me. My engagement in the research then extended further to provide insights into how important the role of the therapist is within the therapeutic relationship. However, perhaps one of the most profound insights gained through the research was how people who have experienced the most horrendous personal adversities can demonstrate the courage and capacity to face these experiences within their therapy and have the potential to move towards a future that is vastly different to the lives they lived in the wake of their traumatic experiences. In recognising these different strands of insight during through my research experiences, I felt that I was making important links between research, theory, and therapeutic practice, all set against the backdrop of the varied participants' life experiences.

As I now reflect back on these research experiences I increasingly realise how my development as a researcher has become an essential part of my conceptualisation of myself as a scientist-practitioner. I feel I have increasingly brought together my research experience, my academic knowledge around psychological theory, and their relationship to my therapeutic practice. As I move towards qualification as a Counselling Psychologist, the importance of this synthesis of these aspects within the role has been an important insight for my future practice. It has highlighted to me the responsibility and importance of my role in providing the therapeutic setting through which the people who seek our services can make the changes to their lives, moving from distress and anxiety towards the potential for life changing personal growth.

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# **Appendices**

## **Appendix 1: Transcription key**

### **When reading the transcriptions please note:**

**All real names have been changed throughout the text to pseudonyms to ensure anonymity and confidentiality.**

**Text enclosed in square brackets non-italics represents substituted insertions in place of any redacted identifying information such as place names, identifying dates, or work roles. Examples:**

- [Organisation name]
- [Town name]

**Text in italics, enclosed in square brackets informs the reader of something happening in the recording.**

**Examples:**


- [*Telephone ringing*]
- [*Pause*]

**Text enclosed in round brackets is information from the transcriber.**

**Examples:**

- (Inaudible)
- (Unsure spelling)

## Appendix 2: Therapist introductory letter

South Staffordshire and Shropshire Healthcare   
NHS Foundation Trust  
A Keele University Teaching Trust



[Patient Address]

[Date]

Dear **[Patient name]**,

I am writing to you following the completion of your therapy with me in the last twelve months to ask whether you would consider being involved in some research our service is assisting with concerning your experience of your therapy and the positive changes you may have experienced whilst going through therapy.

The research is being carried out by David Pennington who is a Counselling Psychologist trainee from the University of Wolverhampton and his research involves interviewing people who have been through therapy in order to consider how the assistance of their therapist may have helped them recover from their trauma and move on positively with their lives.

If you would like to take part in the study and help David with his research then could you please read his introductory letter and information sheet enclosed with the consent form before contacting him directly at our office on 01952 613822 if you wish to discuss being involved in the research.

Please be aware that you are under no obligation to take part in the research but feel free to contact David for any further information about involvement in the research before you make your decision.

Yours sincerely

**[place holder for therapist name]**

### Appendix 3: Researcher introductory letter

South Staffordshire and Shropshire Healthcare   
NHS Foundation Trust  
A Keele University Teaching Trust



**Researcher: David Pennington**  
**Counselling Psychologist in Training**  
*Practitioner Doctorate in Counselling Psychology*  
*Dept of Psychology*  
*Faculty of Education, Health & Wellbeing*  
*University of Wolverhampton*  
*Mary Seacole Building*  
*Nursery Street*  
*Wolverhampton WV1 1AD*  
*Contact: [email address retracted]*

Dear Participant,

My name is David Pennington and I am a Counselling Psychologist trainee from the University of Wolverhampton where I am studying for my doctorate in the Faculty of Education, Health & Wellbeing.

I have been studying and training at Wolverhampton University for the past three years and as part of my final year doctorate studies I am carrying out some research which considers the experiences of people who have been through traumatic life events and how they recover from these events, and move on with their lives.

For some people this process of recovery after a trauma is a natural one and they do not require any additional help but very often people are referred to a psychological therapy team for help in adjusting to their experiences and to help begin to recover from their trauma.

My research considers how these therapies can help people recover from their experiences by also looking at the positive changes that people can make in their lives and their relationships as they work through their traumatic experiences with their therapist.

The Shropshire, Telford, and Wolverhampton Healthy Minds Psychological Therapies Services are involved in this research project and as you received therapy for your difficulties from one of these services, I am therefore writing to ask if you would consider being involved in my research study.

You do not have to take part in the research if you do not want to but in order to help you decide if you would like to be involved I have enclosed an information sheet and consent form which I would ask you to read before making any decision. They provide much more detailed information about the research and what taking part would involve for you.


Your welfare and confidentiality are very important and within the information sheet this is also explained more fully. To ensure your welfare further I am also supervised in my research by Dr Wendy Nicholls and Dr Lee Hulbert-Williams who are senior lecturers in Psychology at the University of Wolverhampton and the University of Chester.

Thank you for taking the time to consider being involved in my research.

Yours sincerely

David Pennington

**Appendix 4: Participant research information sheet**

South Staffordshire and Shropshire Healthcare   
NHS Foundation Trust  
A Keele University Teaching Trust

**Experiences of posttraumatic growth following therapy: The Role of the Therapeutic Relationship in Facilitating Growth.**

Dear Participant,

Please read the following information sheet to understand why the research is being done and what it involves for you before deciding if you wish to take part.

**What is the research about?**

The study is exploring peoples' experiences of therapy following traumatic or distressing events and the positive changes that may have occurred for you during your time in therapy.

**Why have I been chosen and what are the benefits of being involved?**

Thank you for considering taking part in my study. You have been approached for your help with the research as you have completed a course of therapy with the psychological therapy service within the past year and so it would be helpful to my research to gain an account of your experience of being in therapy and how this may have helped you with your difficulties. Understanding of the changes that occurred for you will help to provide improved services for people in your position in the future.

**What will I have to do if I agree to take part in the research?**

If you agree to take part in the research this will involve an interview with me to discuss your experiences of therapy and the changes you experienced. The interview would take place either at your treatment centre or in your own home and would be confidentially audio-recorded. It will take up to 90 minutes. The audio-recording of our conversation would then be transcribed and anonymous quotes from your interview may be used within my final research which will be published as a research paper.

**Are there any possible down sides to participating and how am I supported with these?**

Given that we will be discussing your therapy experience, this may involve talking about your past trauma during the interview and this could potentially be uncomfortable or distressing. If this is the case then it will be possible to have a further follow-up session with your therapist to assist with these emotions and you are advised to contact your therapist to arrange this, or alternatively contact your doctor's surgery or out of hour's service if your distress is unmanageable.

**Is the information I provide confidential and secure?**

Following the recording of your interview I will then listen back to the recording and produce an anonymous written transcript of our conversation. The audio-recording and the transcript will be held electronically on a password protected encrypted file at the University of Wolverhampton. Only the researcher and his supervisors will have access to these and the electronic storage is governed by the Data Protection Act. A copy of the anonymous written transcript will also be available to the academic assessors responsible for my final degree.

For the purpose of the research, direct quotes from your interview which are relevant to the research may be reproduced within my written research report. This report will be published within an academic journal. You will not be personally identifiable within the interview transcriptions, in any selected quotes, or in the final published research report, as only a pseudonym fictional name will be made reference to.

Your identify will be protected and you will remain anonymous by providing a five-part code taken from the last three digits of your phone number and the first 2 letters of your mother's maiden name.

Your contact information provided will be held securely within locked filing cabinets within the University of Wolverhampton secure premises. Upon completion of the research your information will be retained securely within the University of Wolverhampton premises for a period of five years after publication of the research. It will then be confidentially destroyed in line with data protection policies of the University.

If you agree to take part in my study I will be required to inform your doctor that you are taking part in the study by letter. A confidential letter will be sent to your doctor by your therapist informing them about my study and your involvement in it.

**Can I withdraw from the research if I change my mind?**

If you decide at any point during the research or the interview that you no longer feel you want to continue to be involved for whatever reason then you are totally free to discontinue and withdraw from the research. The information you may have provided up to that point will be securely destroyed.

**Will I be able to read about the outcomes of the research?**

At the end of the research a written summary of the findings will be made available in March 2016 and you can obtain a copy of this by emailing or writing to me at the address below.

**What do I do next if I want to be involved in the research?**

If you decide you would like to take part in the research interview and have read and understood the information about the research and what it involves, you will then need to complete and sign the enclosed consent form to say that you agree to take part. Once completed, please then place this form in the envelope marked *Confidential* ready for when we meet for the interview. I would then ask that you contact me directly either by phone on **[Tel N° retracted]**, or by email at **[address retracted]** to discuss your involvement and arrange a suitable time and venue to carry out the interview.

If you wish to discuss any part of the research or need further information before agreeing to take part then please feel free to email me at: **[address retracted]** or contact me on **[Tel N° retracted]**. Alternatively, for more general information about taking part in research in the NHS, you can contact the Patient Advice and Liaison Service who are aware that my study is taking place and can be contacted on either 01785 221469 or 0121 612 8030.

Thank you for your participation

David Pennington


**Researcher: David Pennington**  
**Counselling Psychologist in Training**  
*Practitioner Doctorate in Counselling Psychology*  
*Dept of Psychology*  
*Faculty of Education, Health & Wellbeing*  
*University of Wolverhampton*  
*Mary Seacole Building*  
*Nursery Street*  
*Wolverhampton WV1 1AD*

**Supervisor: Dr Wendy Nicholls**  
**Senior Lecturer in Psychology**  
*Faculty of Education, Health & Wellbeing*  
*University of Wolverhampton*  
*Mary Seacole Building (MH009)*  
*Nursery Street*  
*Wolverhampton WV1 1AD*  
*Email: [email address retracted]*

**Supervisor: Dr Lee Hulbert-Williams**  
**Senior Lecturer in Psychology**  
*Department of Psychology*  
*University of Chester*  
*Parkgate Road*  
*Chester CH1 4BJ*  
*Email: [email address retracted]*



**Appendix 5: Interview consent form**

South Staffordshire and Shropshire Healthcare   
NHS Foundation Trust  
A Keele University Teaching Trust



**Researcher: David Pennington**  
**Counselling Psychologist in Training**

*Practitioner Doctorate in Counselling Psychology  
Dept of Psychology  
Faculty of Education, Health & Wellbeing  
University of Wolverhampton  
Mary Seacole Building  
Nursery Street  
Wolverhampton WV1 1AD  
Email: [email address retracted]*

**Posttraumatic Growth and Therapy Consent Form**

(Before completing this consent form please read the information sheet provided)

I would like to participate in the research being carried out by David Pennington (University of Wolverhampton, Faculty of Health, Education and Wellbeing) as part of his doctoral research into posttraumatic growth and therapy. I have read and understood the information sheet provided which describes the study and my involvement.

Please tick  
box

1. I understand that taking part in this study is entirely voluntary and that I can withdraw from the study at any point without giving a reason. ☐
2. I understand that taking part in this study involves being interviewed by the researcher about my experiences of therapy, my past trauma, and the changes that have taken place for me, and the interview will be audio-recorded. ☐
3. I understand that a written, anonymised transcription of our interview conversation will be produced and this will be held confidentially in electronic password protected and encrypted format. ☐
4. I understand that only the researcher, his supervisors, and external examiners who are required to assess the researcher's work, will have access to my anonymised transcript. ☐
5. I understand that any information and personal contact details I provide will be held confidentially and stored securely either physically, in locked filing cabinets in the secure premises of the University of Wolverhampton, or electronically in password protected, encrypted files on a secured computer on the premises of the University of Wolverhampton. ☐

6. I understand that all measures to maintain the confidentiality of my personal information and contact details comply with the Data Protection Act. ☐
7. I understand that extracts from my interview may be used in the researcher's doctoral research report which may also be published in an academic journal and that I will not be personally identifiable from my responses as my identity will be disguised. ☐
8. I understand that relevant data collected during the study may be looked at by individuals from the University of Wolverhampton, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. ☐
9. I acknowledge that I have read and understood the participant information sheet provided and I have had the opportunity to ask any questions and have had these answered satisfactorily. ☐
10. I agree that my GP can be informed by letter of my involvement in this research. ☐
11. I am at least 18 years of age and I agree to participate in this research. ☐

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**Appendix 6: Semi-structured interview schedule****Question 1:**

Can you tell me what led to you seeking help from the psychological therapy service?

- *(Prompt: Can you tell me how you had coped before your therapy)*

**Question 2:**

What expectations did you have about therapy?

**Question 3:**

Could you tell me about any positive changes you experienced during your time in therapy?

- *Prompt: Did anything change for the better?*
- *Prompt: Do you feel you're a different person because of the therapy?*
- *Prompt: What changes have you experienced about your attitude towards life?*

**Question 4:**

What was your therapist like to be with?

**Question 5:**

Please could you tell me about your experience of working with your therapist?

- *Prompt: Could you describe a typical therapy session for me?*

**Question 6:**

Can you describe the role of your therapist as you made these changes?

- *Prompt: What was the quality of the working relationship you had with your therapist?*
- *Prompt: In what ways was your therapist influential to you making these changes*

**Question 7:**

How did you feel about working on your difficulties with your therapist?

- *Prompt: What was the best experience, the most challenging experience, and key points in the therapy*

**Question 8:**

To what extent has the therapy matched your expectations?

**Question 9:**

How do you view your situation and the future now?

**Appendix 7: Demographics sheet**

South Staffordshire and Shropshire Healthcare   
 NHS Foundation Trust  
 A Keele University Teaching Trust



**Instructions: Please complete the following form providing your contact details and further information.**

**Your contact details:**

**Name:**.....

**Address:**.....  
 .....

**Tel No:** .....

**Instructions: Please tick the relevant box**

**Sex**..... **Male** ☐ **Female** ☐

**Age**..... ☐

**What is your relationship status?**

**Single** ☐

**In a relationship** ☐

**In a relationship (Co-habiting)** ☐

**In a relationship (Married)** ☐

**Separated** ☐

**Divorced** ☐

**Other**.....

(please describe).....

*Continued overleaf:*

**Please provide the last three digits of your phone number which will be used as part of your anonymous code number:**

**Please provide the first two letters of your mother's maiden name which will be used as part of your anonymous code number:**

**Please state the type of therapy you received from the psychological therapy service over the past year:**

EMDR

☐

Trauma-focused CBT

☐

**Please state when you finished your therapy:**

Month


Year

**Appendix 8: Psychological Well-Being -Post-Traumatic Changes Questionnaire**

**Instructions:** Think about how you feel about yourself at the present time. Please read each of the following statements and rate how you have changed as a result of the trauma.

		Much less so now	A bit less so now	I feel the same about this as before	A bit more so now	Much more so now
1	I like myself	1	2	3	4	5
2	I have confidence in my opinions	1	2	3	4	5
3	I have a sense of purpose in life	1	2	3	4	5
4	I have strong and close relationships in my life	1	2	3	4	5
5	I feel I am in control of my life	1	2	3	4	5
6	I am open to new experiences that challenge me	1	2	3	4	5
7	I accept who I am, with both my strengths and limitations	1	2	3	4	5
8	I don't worry what other people think of me	1	2	3	4	5
9	My life has meaning	1	2	3	4	5
10	I am a compassionate and giving person	1	2	3	4	5
11	I handle my responsibilities well in life	1	2	3	4	5
12	I am always seeking to learn about myself	1	2	3	4	5
13	I respect myself	1	2	3	4	5
14	I know what is important to me and will stand my ground, even if others disagree	1	2	3	4	5
15	I feel that my life is worthwhile and that I play a valuable role in things	1	2	3	4	5
16	I am grateful to have people in my life who care for me	1	2	3	4	5
17	I am able to cope with what life throws at me	1	2	3	4	5
18	I am hopeful about my future and look forward to new possibilities	1	2	3	4	5

**Appendix 9: Interview debriefing sheet**

South Staffordshire and Shropshire Healthcare   
 NHS Foundation Trust  
 A Keele University Teaching Trust

**Experiences of Posttraumatic Growth During Therapy**

Thank you for participating in this study. This research has been carried out to consider the positive psychological changes that can occur for people who have been through the therapy process. For many people who have faced major life adversities they can find that the experience sometimes changes them in positive ways such as having clearer priorities in life around their relationships, their goals and their abilities to cope. This has often been described as a natural process of recovery but this research also set out to consider whether the process of working through trauma related difficulties with a therapist not only leads to a reduction in distress but may also result in more positive personal and psychological changes.

**Main expectations.**

The interview process with you therefore set out to consider your own personal experiences during therapy and how the therapeutic relationship you had with your therapist may have had in helping to facilitate any positive psychological changes and personal growth. Through this process of interview it was anticipated that your experiences would provide insights into how the relationship with your therapist helped you to change in positive ways.

**The relevance of this research.**

It is particularly important to consider how the relationship a patient has with their therapist can impact on positive psychological changes because findings around this could help to improve the process of therapy for people in the future through greater understanding and knowledge.

If you would like a summary of the research upon completion of the study, or you wish to ask any further questions about the research, then please contact David Pennington on [email address retracted].

Thank you for your participation.

**Researcher: David Pennington**  
**Counselling Psychologist in Training**  
*Practitioner Doctorate in Counselling Psychology*  
*Dept of Psychology*  
*Faculty of Education, Health & Wellbeing*  
*University of Wolverhampton*  
*Mary Seacole Building*  
*Stafford Street*  
*Wolverhampton WV1 1SB*  
*Email: [email address retracted]*

**Supervisor: Dr Wendy Nicholls**  
**Senior Lecturer in Psychology**  
*Faculty of Education, Health & Wellbeing*  
*University of Wolverhampton*  
*Mary Seacole Building (MH009)*  
*Stafford Street*  
*Wolverhampton WV1 1SB*  
*Email: [email address retracted]*

**Supervisor: Dr Lee Hulbert-Williams**  
**Senior Lecturer in Psychology**  
*Department of Psychology*  
*University of Chester*  
*Parkgate Road*  
*Chester CH1 4BJ*  
*Email: [email address retracted]*

*Please turn over:*

**In the event of you requiring immediate support for any unmanageable symptoms then you are advised to contact your doctor's surgery or the out of hour's service in your area.**

**We also advise that you contact the psychological therapy service to which you were originally referred.**

**Other sources of support for general psychological and emotional distress include:**

**The Samaritans National Helpline:**

08457 90 90 90

**Mind National Helpline:**

[0300 123 3393](tel:03001233393)

**Telford Mind Drop-in Centre**

01952 588367



## Appendix 10: GP template letter

South Staffordshire and Shropshire Healthcare   
NHS Foundation Trust  
A Keele University Teaching Trust



[ Insert GP name and address ]

**David Pennington**  
**Counselling Psychologist in Training**  
*Practitioner Doctorate in Counselling Psychology*  
*Faculty of Education, Health & Wellbeing*  
*University of Wolverhampton*  
*Mary Seacole Building*  
*Nursery Street*  
*Wolverhampton WV1 1AD*  
*Email: [email address retracted]*

Dear [insert GP name]

I am a trainee Counselling Psychologist studying for the Practitioner Doctorate in Counselling Psychology at the University of Wolverhampton, Faculty of Education, Health & Wellbeing. I am currently carrying out a research study for my doctoral thesis around post-traumatic growth and psychological wellbeing following trauma-focused therapies within NHS Psychological Therapy services.

In relation to this, a patient you referred to the [INSERT NHS service], [INSERT CLIENT NAME], has kindly consented to be involved in my research study which will involve filling out a post-therapy trauma-related questionnaire and attending a follow-up interview with myself to discuss their therapy experiences and any changes in their psychological wellbeing and growth.

The study is supervised by two members of the Psychology departments at the University of Wolverhampton and the University of Chester and has been granted ethical clearance both by the university ethics committees and the NHS research ethics committee. The research will conform to all ethical guidelines and is informed by the British Psychological Society's Code of Ethical Research Practice.

The service to which you referred the patient is fully involved with the research process and planning.

I have enclosed a copy of the research information sheet provided to your patient for your reference but if you require any further information then please do not hesitate to contact me.

Yours sincerely

David Pennington  
University of Wolverhampton, Faculty of Education, Health and Wellbeing

## Appendix 11: Example 2<sup>nd</sup> stage transcript analysis

**P:** Erm, but you know, I did feel, I, I felt that she listened...

**I:** Yeah.

**P:** ... to erm, to what I was saying.

**I:** Yeh.

**P:** Erm... and not only listening, she *heard* it.

**I:** Yeh.

**P:** Which, for me personally, I think there's a big difference between somebody who listens and somebody that hears.

**I:** Yeh. And what... go on...

**P:** And I just felt like, that she actually heard what I was saying.

**I:** And how did you feel that? How did you?

**P:** I think it's, erm, I felt important in so much the fact that, erm, I'd got somebody's time for, you know, an hour, but during that hour they were completely mine.

**I:** Mmm.

**P:** Erm, and I suppose, sort of, having that attention and actually being heard. And I felt as well, I don't know whether it's Sarah's experience or whether it was the EMDR therapy, or what have you, but I had actually felt that Sarah heard a lot of, unsaid things...

**I:** Oh okay.

**P:** ... from what little bits I said, she could almost see that there was more waiting to come out.

**I:** Yeh?

**P:** And I suppose there was in a way, because a lot of, erm, things that I felt showed weakness on my part, I keep hidden.

**I:** Mmm.

**P:** Erm, whereas she obviously knew there was more waiting to come out and she managed to coax it out of me. And I don't think it would have worked quite so well if she hadn't of heard the unheard, if that makes sense.

**I:** Yes. So hearing the unheard?

**P:** Yeh, knowing, being able to tell by somebody's responses and their body language that there is something being left unsaid.

**I:** Yeh.

**P:** Because I just think, as, as humans and emotions, there's a lot of things that we keep hidden which really we should be able to share with people.

**I:** Mmm. So what would you describe that quality in your therapist Sarah was? How would you describe that?

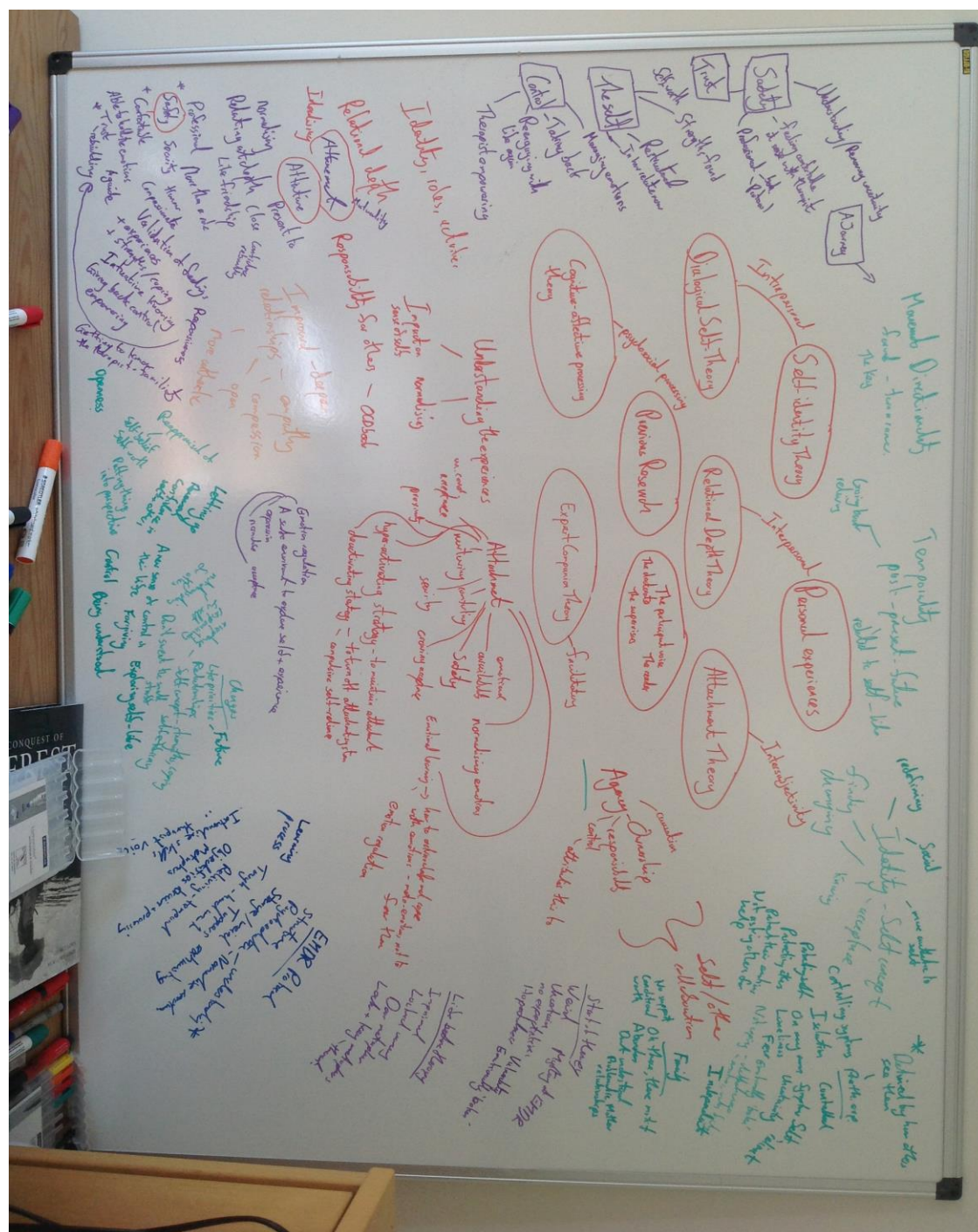
**P:** Erm... erm, compassionate, and is it emp... empathic? Empathy? I felt that she got, you know, she understood, I just felt that she understood what I was trying to say. Erm...

**I:** So you said empathy...

**P:** Yeh. And compassion.

Meaning units	
Therapist attuned deeply hearing those things implicit, an intuition	
Therapist's presence, attending to her – her self worth validated	
She had an impression of her therapist as seeing beyond words.	
Therapist was able to help her open to that which she felt was a weakness.	
The hidden parts to her  Opening up to her experiences encouraged by therapist	
The embodied communication was attended to, therapist attuned to this.  Objectifying the hiding to others, is she referring to herself here still.	
Compassionate and empathic.	
Therapist understanding at a deeply attuned level	

## Appendix 12: Researcher whiteboard workings



**Appendix 13: Example 3<sup>rd</sup> stage transcript analysis**

**P:** I didn't realise what's going to come next when you start really but erm, yeah it was, it gave you the confidence to keep going actually.

**I:** It gave you the confidence?

**P:** Yeah yeah cos you think...

**I:** What gave you the confidence?

**P:** Just thinking, 'Okay I could do the mapping, that I was in a room with somebody that had got these tappers and that it wasn't stupid, I was learning, all those things really enforced the positive if you like.

**I:** Yes.

**P:** And so I was getting to know Lisa...

**I:** Oh okay.

**P:** ... and I was getting comfortable...

**I:** Yeh.

**P:** ... with the close proximity in which we were sat.

**I:** Yes.

**P:** Then, because if you think when you make, like I said to you, you could be in a crowded room or you could be in a desert, you're on your own, you also put up this barrier where you don't like people to come into you, erm, and you learned that, I mean you can be a bit like Basil Fawlty really it sort of augmented at times and stepping away from people but it is actually what happens.

**I:** Yes.

**P:** Or did happen to me. So it was nice to be able to learn that I'm okay with this stranger, I'm okay that she knows what she's doing and she's giving me answers to things that I just don't understand.

**I:** Yeh. And you said 'becoming comfortable'?

**P:** Yeah.

**I:** With her?

**P:** Yeah because you're, one of the things is like in society you don't go up to someone and say 'Hi I've been sexually abused have you?' do you?

**I:** No.

**P:** It's something we don't talk about, we don't want people to know because we already feel pretty shit.

**I:** Mmm.

**P:** So to think you're actually going to come in and concentrate on that, you have to learn that that person's okay...

<u>Meaning Units</u>	<u>Thematic content</u>
The process itself provided growing confidence	Developing confidence
A learning process	
Getting to know the therapist	Comfortable and at ease with therapist
Familiarity with the therapist. Being comfortable with the therapist.	
The intimacy of being with the therapist is something she learned to feel safe with. Presence of the therapist important. Learning to be comfortable with someone.	
Isolation self from others Defended herself by stepping away – deactivating.	Hidden away
This was in the past now.	
Learning to be comfortable with strangers, trust.	Developing trust
The knowledge and experience of the therapist important to comfort. Explaining like a parent would.	
Therapy context a unique context in comparison to normal daily life.	Professional and Knowledgeable
Keep it hidden, its taboo, or the stigma of it,	Hidden away
Affected her feelings and self-worth.	.
Learning the person is okay...trusting them.	Developing trust

## Appendix 14: Example participant abstracted themes

### Emergent superordinate themes

#### Emerging themes

Meaning units

#### Locked away and hidden

##### *Locked in*

Door metaphor  
Affected feeling of safety  
Life was dangerous and fearful  
Pre fear and frightened to go out  
Fearful of letting in, protecting self  
Lived inside herself, locked in maybe

##### *Avoiding life*

Pre Secluded person  
Things were unsafe before  
Pre was fearful afraid to hurt others.  
Second rape hidden and not talked about  
Breaking down  
Her brain had hidden it that well – objectifies the process.

##### *Protecting others*

Kept it hidden  
To protect father's emotions

### Participant 2: Susan

#### Safe and Secure

##### *Uncertainty and lack of understanding*

All very uncertain about the duration of therapy  
Confusion at the start uncertainty  
Confusion about what EMDR involved at start  
A mystery as no understanding  
Understanding was important and the explanation from the therapist  
Uncertainty at the start  
Doubting the treatment as not understanding  
Being understood is important  
Understanding important to her  
Discomfort at start  
Commitment to the process despite doubts

##### *Starting out with caution*

Starts the therapy with some fear.  
Confidence low at start  
Therapy outset nervous start  
Therapist cautions at the start  
Technique allied to dialogue talking through provided understanding.

##### *Comfortable and at ease with the therapist*

Presence and proximity of therapist puts her at ease  
Needing to be comfortable  
Being comfortable important to her.  
Therapist considerate towards her and the sensitivity of her story  
Taking things slowly was important for her (uses the word slowly before this)  
Internalises the feelings of comfort to herself also  
Make you feel comfortable, they are committed to want to help you  
Recognition of importance of being comfortable with therapist in therapy to open up and talk

##### *Therapist attunement*

Therapist considerate  
Therapist sensitive to her emotional state – attuned  
Therapist self aware so as to guide their interaction. Be sensitive to the clients emotions.  
Therapist protecting her emotionally  
Comfortable with therapist – a sense of safety.

##### *Responsiveness*

Therapist's responsiveness important to her feelings  
Therapist holding back to protect her

Key moment, the therapist stopping it being attentive to her emotions.  
She could not take control of this.  
Responsive to client  
Recognition of therapy as relational

##### *Presence of the therapist*

The proximity of the therapist puts her at ease  
Seem like your friend  
Not quite a friendship but with some qualities of a friendship  
Being known important to experience of opening up.  
Couldn't do it on own.  
Collaborative  
The therapists qualities thoughtful considerate to her feelings, almost anticipating her feelings, attending to her

##### *Learning to trust again*

Learning to trust (males) again  
Learning to open up to others provides the understanding and care.  
Like friendship with therapist  
Feeling understood by therapist, There for her like a parental figure  
Provided her with safety.  
Client has to believe in the therapist is going to help. Trust  
That he had been considerate towards her and her feelings, is this reparative, restoring her confidence in men?  
He hadn't been dismissive and carried on  
Trust important to her



**Taking back control*****Learning to regulate emotions***

Hard to express the emotions for her  
 Hard to cope with the emotions at the start  
 Therapist showing concern for her emotional state helped a lot  
 But also within her sense of self and acknowledging it to herself, a sense of self discovery and emotion regulation  
 Changed in terms of how she copes emotionally with the rape  
 He'd facilitated her sense of control of how far she wanted to proceed.  
 There was a calming sense emotionally from his demeanour  
 Not forcing her.  
 She takes control  
 Links between her sense of control and feeling better in herself.  
 Ownership of control  
 Clicked on a certain level.  
 Fragile, therapists approach is key to clicking  
 A guiding role for the therapist – like a parent  
 Not just the technique but allied to the therapist talking her through

***Reconnecting with life***

Now can go on her own rather than needing the support of others, exploring on her own.  
 Confidence now in the doing and the being on own  
 Holidaying with kids  
 Retuning to a previous sense of self.  
 Relational reconnecting with wider family ie brother  
 The more authentic self and a sense of her values  
 Aspiring to a career, not just accepting.

***Therapist enabling control***

Provided her with agency to take the lead on disclosure

**Reconstructing self**

Mutuality and compassionate.  
 The inner 'I' instructing the outer 'me'.

***Reappraising responsibility***

self-evaluation - Doubting self again, self-blame  
 Newfound self-worth

***Self in relation to others***

Pretherapy self doubting / self blaming  
 An assertive authentic self  
 More independent but also improved relationships  
 Existing relationships improved  
 Changed in how she thinks of others perceiving her or judging her.  
 Openness with brother and sister.  
 Defines herself relationally  
 Relationally changes with children.  
 A deepening of relationship, more openness and mutuality in sharing difficult experiences  
 Friendship attachment, emotionally close, someone to turn to  
 Relationally more open to others  
 Turning to social support important to her getting through

***Self-worth***

Taken for granted by others before, not worthy to be valued,  
 Self-worth developing closer relationships with men

***Growing confidence***

Confidence wasn't high before  
 Confidence felt sense of it growing  
 Confidence in doing things on own  
 Therapist aided growing confidence

**A journey through therapy to the future*****Temporal change***

Seeing things from temporal perspective  
 Temporal change over time, different now  
 Temporal change from how was, avoiding, to how is, confronting.  
 Back down that road, temporal and spatial journey with road metaphor  
 Change over time – temporal defining of change.  
 Living life to the full

***Future orientated***

A different philosophy of life now  
 A change of attitude to life  
 Seeing a future now

***Movement metaphors***

Metaphor of a milestone – the journey she was on  
 The metaphor of movement had previously been her running away, now she was looking forward  
 Looking back looking forward. This is how she sees progression from now on  
 Locates the trauma behind her temporally now  
 Directionality again 'moving on'  
 Looking forward in life now.  
 A recognition that traumas could happen again, realistic vulnerability.  
 Emphasises the importance of this change in how she manages her emotions.  
 Comfortable again but not in relation to self or to another but located spatially within the home  
 Discomfort. Home was a place of fear  
 Feels more secure now  
 Sees the achievement from a overall perspective as a whole

***Reprioritising the future with family***

Prioritising relationships  
 Enjoying the relational with kids  
 More compassionate

***Reprioritising goals for future***

Aspiring to a career, not just accepting.  
 Family priorities - engaging with her kids now in going out holidays

## Appendix 15: Example participants' theme / extracts spreadsheet

Participant	Safe and Secure		
	<i>Allying uncertainty</i>	<i>Comfortable &amp; at ease</i>	<i>Professional and knowledgeable</i>
<b>Liz</b> Extracts	17 - Truthfully, I didn't think it would help. I actually believed I was beyond help.	259 - P: [pause] He actually made me feel quite safe to talk about stuff that I didn't want to talk about. P: Erm, I know that kind of plays into the trust bit, but it also... the fact that I felt at ease enough to do that...	288 - P: I think he... he never seemed to judge me. P: And he never, you know, [pause] he, he just kind of kept me safe.
<b>Susan</b> Extracts	716 - To start off with I was nervous, erm, I kinda held back slightly... because I didn't know how he, what type, how he was gonna work with me or how I was gonna work with him... you know, what the relationship was gonna be like.	1032 - P: And it makes you feel more comfortable and more at ease, the fact that they know this, and you can just open up and...	914 - P: ... at any point, if I felt uncomfortable, that I was to just stop it, say my safe word or put my hand up, and it made me feel at ease knowing that it wasn't just a case of 'Oh we need to get through this' ...
<b>Linda</b> Extracts	87 - it made me understand that it is just the way my brain had processed, or not processed what had happened, rather than me as a person. 800 - how the EMDR therapy works, that it's to try and help to reprocess and reorder these memories in the brain and make it sort of safe... 158 - P: Erm, but to be able to go through the EMDR and understand the process of it...	575 - Linda: Erm... erm, compassionate, and is it emp... empathic? Empathy? I felt that she got, you know, she understood, I just felt that she understood what I was trying to say. Erm... Interviewer: So you said empathy... Linda: Yeh. And compassion. Interviewer: Compassion? Yeh. And that was important to you? Linda: Yeh because it made me feel safe enough to erm, expose my vulnerabilities...	899 - P: I mean I know it's not easy and I know there's a lot of science behind it and you know the whole sort of like, you know, erm hippocampus and the cortex and amygdala and all that sort of stuff. You know, I understand all that. Erm, I do, I do think if I hadn't got the level of intelligence that I have, if erm, if I hadn't of understood the science behind it, I don't think it would be, it would have been quite as successful. 553 - P: Erm, and I suppose, sort of, having that attention and actually being heard. And I felt as well, I don't know who

## Appendix 16: SAS Student management board research proposal approval

From: Kaur, Ramanjit  
Sent: 06 February 2013 14:24  
To: Pennington, David; Nicholls, Wendy  
Subject: Research Proposal

Dear all,

Re: David Pennington – Professional Doctorate in Counselling Psychology

Just to confirm the above research proposal has been approved by chair's action.

Regards,  
Raman

Mrs Raman Kaur  
Research Administrator  
Research Institute in Healthcare Science  
School of Applied Sciences  
University of Wolverhampton  
Wulfruna Street  
Wolverhampton  
WV1 1LY

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## **Appendix 17: BSEC Ethical Approval**

### **School of Applied Sciences**

#### **Minutes of the School Ethics Committee (SEC)**

**Wednesday 17th July 2013**

**MCb12**

Present: Dr N Morris (Chair), Dr I Coleman, Professor R Morgan and Mrs K Safi (Minutes)

1. **Apologies** were received from Dr V Galbraith, Professor K Manktelow
2. **Minutes of the last meeting (05.06.13)**: Agreed as accurate.

3. **Matters arising**: None

4. **RES20B Submissions**:-

4.1

- 4.2 **David Pennington**  
Supervisors: Dr W Nicholls and Dr L Hulbert-Williams

**Comments:** Add to consent form that external examiners may have access to anonymised data.

**Approved with supervisor to monitor.**

**Appendix 18: NRES Ethical Approval Original Submission****Health Research Authority****National Research Ethics Service****NRES Committee West Midlands - The Black Country**

HRA NRES Centre Manchester  
3rd Floor, Barlow House  
4 Minshull Street  
Manchester  
M1 3DZ

Telephone: 0161 625 7821  
Facsimile: 0161 625 7299

26 November 2013

Mr David Pennington  
Practitioner Doctorate in Counselling Psychology  
University of Wolverhampton  
University of Wolverhampton, Faculty of Education, Health & Wellbeing,  
Mary Seacole Building, Stafford Street,  
Wolverhampton  
WV1 1AD

Dear Mr Pennington

**Study title:** Experiences of Posttraumatic Growth during Therapy:  
The Role of the Therapeutic Relationship in Facilitating  
Growth  
**REC reference:** 13/WM/0423  
**Protocol number:** N/A  
**IRAS project ID:** 128157

Thank you for your letter of 18 November 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Alternate Vice Chair and Reverend Mark Stobert.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager, Miss Shehnaz Ishaq, [nrescommittee.westmidlands-blackcountry@nhs.net](mailto:nrescommittee.westmidlands-blackcountry@nhs.net)

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		04 October 2013
Evidence of insurance or indemnity		19 July 2013
GP/Consultant Information Sheets	1	23 September 2013
Interview Schedules/Topic Guides	Appendix R - Semi Structured Interview Schedule - version 2	18 November 2013
Investigator CV	David Pennington	05 October 2011
Investigator CV	Wendy Nicholls	
Investigator CV	Lee Hulbert-Williams	
Letter of invitation to participant	Appendix U - Research Introductory Letter version 2	18 November 2013
Participant Consent Form: Appendix N - Phase 1 Consent Form - Wait List Control Group	2	18 November 2013
Participant Consent Form: Appendix F - Phase 1 Consent Form - Treatment Group	2	18 November 2013
Participant Consent Form: Appendix Q - Phase 2 Interview Consent Form	2	18 November 2013
Participant Information Sheet: Appendix E - Treatment Group Participants	2	18 November 2013
Participant Information Sheet: Appendix P - Phase 2 Qualitative Interview Study	2	18 November 2013
Participant Information Sheet: Appendix M - Wait List Control Group Participants	2	18 November 2013
Protocol	2	18 November 2013
Questionnaire: Impact of Event Scale - Revised	1	23 September 2013
Questionnaire: Psychological Well-Being - Post Traumatic Changes Questionnaire	1	23 September 2013
Questionnaire: Traumatic Life Events		
Questionnaire: Traumatic Events Scale	V0.17	
REC application	3.5	11 October 2013
Response to Request for Further Information	Covering letter detailing Response to Provisional Opinion	18 November 2013

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review****Reporting requirements**

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

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- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

#### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

<b>13/WM/0423</b>	<b>Please quote this number on all correspondence</b>
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We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Signed on behalf of:  
**Dr Hilary Paniagua**  
 Alternate Vice-Chair (Chaired the meeting)

Email: [nrescommittee.westmidlands-blackcountry@nhs.net](mailto:nrescommittee.westmidlands-blackcountry@nhs.net)

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Wendy Nicholls, University of Wolverhampton

Ms Audrey Bright, South Staffordshire and Shropshire Healthcare NHS  
 Foundation Trust



**Appendix 19: NRES Ethical Approval Amended Submission**

11 February 2015

**Mr David Pennington**  
**Practitioner Doctorate in Counselling Psychology**  
**University of Wolverhampton**  
**University of Wolverhampton, Faculty of Education, Health & Wellbeing,**  
**Mary Seacole Building, Stafford Street,**  
**Wolverhampton**  
**WV1 1AD**

Dear Mr Pennington

**Study title:** Experiences of Posttraumatic Growth during Therapy: The Role of the Therapeutic Relationship in Facilitating Growth  
**REC reference:** 13/WM/0423  
**Protocol number:** N/A  
**Amendment number:** Version 3 dated 16/01/2015  
**Amendment date:** 22 January 2015  
**IRAS project ID:** 128157

The above amendment was reviewed by the Sub-Committee in correspondence.

**Ethical opinion**

Approval was sought for the request to focus more on the qualitative interview phase of the study and run a second stream to the research focusing more specifically on the interviews, whilst ensuring that it would be nested within the methodological and ethical protocol of the original phase 2 part of the study.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

**Approved documents**

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering letter on headed paper		05 January 2015
GP/consultant information sheets or letters [GP Letter]	1	22 January 2015
Letters of invitation to participant [New Participant Invite Letter]	1	22 January 2015

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Notice of Substantial Amendment (non-CTIMP)	Version 3 dated 16/01/2015	22 January 2015
Other [Research Introductory Letter]	1	22 January 2015
Other [Demographics Sheet]	1	22 January 2015
Participant information sheet (PIS) [Information Sheet - Phase 2 Qualitative interview Study]	1	22 January 2015
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [Revised Research Flow Chart]	1	22 January 2015

#### Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

#### R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

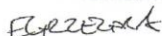
#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

<b>13/WM/0423:</b>	<b>Please quote this number on all correspondence</b>
--------------------	---

Yours sincerely



On behalf of  
**Dr Hilary Paniagua**  
Chair

E-mail: [nrescommittee.westmidlands-blackcountry@nhs.net](mailto:nrescommittee.westmidlands-blackcountry@nhs.net)

Enclosures: List of names and professions of members who took part in the review

Copy to: Ms Audrey Bright,  
South Staffordshire and Shropshire Healthcare NHS Foundation  
Trust

Dr Wendy Nicholls